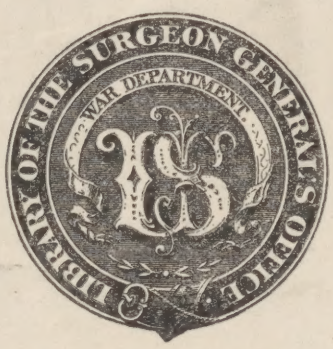
CONFERENCE ON

TUBERCULOSIS ISOLATION



CONFERENCE

ON

TUBERCULOSIS ISOLATION

Sponsored by the
California State Department of Public Health

Held at Los Angeles
March 20, 1943

F O R E W O R D

All agree that the isolation of communicable cases of tuberculosis is an important part of the control program. The concept of forcibly isolating the recalcitrant cases has not been accepted widely in California. In Los Angeles County, however, under the leadership of the late John L. Pomeroy, Health Officer, and Dr. Percy K. Telford, Chief of the Division of Tuberculosis, a policy of enforced isolation, when indicated, has been followed for more than ten years. More recently, other county and city health departments in the state have adopted a similar program.

Because of the success of the program in Los Angeles County, and because of the great need for a careful study of this problem by all interested parties, Dr. Edward Kupka, of our department, suggested that health officers, tuberculosis control officers, sanatorium superintendents, representatives of the State Attorney General's Office, and others meet for the purpose of a round-table discussion. Plans were laid and the meeting held at the State Building in Los Angeles on March 20, 1943.

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FOREWORD

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carrying out isolation, and the solutions or suggestions evoked. The chief barrier to a more active isolation program seems to be a general lack of appreciation of its importance and necessity. Once this has been made clear, health officers, district attorneys, and judges will feel less hesitancy in compelling the isolation of the recalcitrant tuberculous in suitable institutions or other locations where protection will be assured.

The free discussion at the meeting was recorded. The proceedings were moderately abridged and slightly edited; irrevelant material and some case histories were omitted. The resulting text follows. The appendix contains Mr. Martin's legal analysis, pertiment sections of the Health and Safety Code, and the recently adopted tuberculosis regulations of the State Department of Public Health.

WILTON L. HALVERSON, M. D.
Director of Public Health

SUMMARY OF

GENERAL CONCLUSIONS OF CONFERENCE

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1. The local health officer is authorized to quarantine or isolate a person with communicable tuberculosis; he may do this without consultation with or direction from the State Health Department.

2. The local health officer must be prudent in the selection of suitable cases for coercive action; he must be able to show that reasonable cause exists.

3. Enforced isolation is to be resorted to only after thorough trial of persuasion and explanation has been made.

4. A person who breaks tuberculosis isolation is guilty of a misdemeanor, for which he can and should be prosecuted.

5. Recalcitrant tuberculous frequently present complicating factors such as chronic alcoholism or borderline psychosis.

6. The experience in Los Angeles County has shown the practicability of enforced isolation of the tuberculous.

7. A campaign of education on the occasional necessity of enforced tuberculosis isolation is in order.

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ACTIVE PARTICIPANTS IN ORDER OF SPEAKING

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P. K. TELFORD, M. D., Chief, Division of Tuberculosis,
Los Angeles County Department of Health

H. L. WYNNS, M. D., Chief, Bureau of Epidemiology,
State Department of Public Health

W. A. POWELL, M. D., Health Officer, Contra Costa County

JOSEPH L. ROBINSON, M. D., Medical Director, Olive View Sanatorium

CHESLEY BUSH, M. D., Medical Director, Arroyo del Valle Sanatorium

EDWARD KUPKA, M. D., Chief, Bureau of Tuberculosis,
State Department of Public Health

MR. EVERETT W. MATTOON, Assistant Attorney General, Los Angeles

MR. ALLEN L. MARTIN, Deputy Attorney General, San Francisco

MYRNIE GIFFORD, M. D., Assistant Health Officer, Kern County

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CHARLES F. BLANKENSHIP, M. D., U. S. Public Health Service

CHARLES L. IANNE, M. D., Director of Tuberculosis, Santa Clara Co.

JOHN D. FULLER, M. D., Health Officer, Santa Cruz County

EDWARD LEE RUSSELL, M. D., Health Officer, Orange County

WARREN F. FOX, M. D., Health Officer, Riverside County

MISS ZDENKA BUBEN, Director, Bureau of Medical Social Service,
Los Angeles County Health Department

MR. C. O. HARVEY, Quarantine Officer, Los Angeles Co. Health Dept.

S. F. FARNSWORTH, M. D., Health Officer, Alameda County

ROY O. GILBERT, M. D., Assistant Health Officer, Los Angeles County

MR. W. FORD HIGBY, Executive Secretary, California Tuberculosis Ass'n.

CONFERENCE ON TUBERCULOSIS ISOLATION

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DR. BELT: The meeting will come to order. The objective of this gathering is to discuss thoroughly the matter of enforced isolation of recalcitrant tuberculous patients. There are present here representatives of the Attorney General's Office, of the State Department of Health, as well as county health officers, sanatorium directors, social workers, and officials of several tuberculosis associations. Will the following please come forward and sit at this table, to act as an advisory board of experts to whom questions may be addressed: Dr. Pottenger, Dr. Bush, Dr. Telford, Dr. Cohn, Dr. Wynns, Dr. Kupka, Mr. Mattoon, Mr. Martin and Mr. Higby.

The first item on the program is a paper by Dr. Telford which will relate the experience of Los Angeles County in the matter of enforced isolation of the tuberculous and which will serve as a basis for subsequent discussion. I hope this discussion will be as free as possible. Dr. Telford.

DR. TELFORD: Of prime importance in considering the subject of isolation of tuberculosis is the fact that in the dozen years or so that we have been engaged in the work, of all the difficulties and criticisms that we have encountered, no one has ever expressed the opinion that such isolation was not desirable from a medical or epidemiological standpoint, if the procedure was found practicable.

We have, therefore, a sound medical and public health basis for our attempt to segregate the spreaders of this disease.

There were a number of circumstances that persuaded us to embark on this attempted isolation. In the first place, it was realized that the incidence of the disease has been reduced to a low enough level that we could begin to consider the possibility of exercising control over the most dangerous cases, at least. That this procedure was becoming possible at this time was due largely to the great increase in institutional beds devoted to the care of the tuberculous patient. In the early period of the rapid and widespread development of tuberculosis sanatoria, their prime purpose was usually stated as being particularly for the care of early, minimal cases that could be expected to be improved by institutional treatment. The proportion of minimal cases found in clinic work and surveys became a fetish and an obsession. It soon dawned on us that we were sending many minimal cases to the institution that were not active, and repeated studies of the fate of the minimal cases discovered showed that the care of minimal cases was not a major part of the campaign against tuberculosis. We found that the minimal cases that stayed at home had a better record than those that went to the institution--which fact could not be accepted at its face value, because, of course, the worst cases were more easily induced to go to the sanatoria, and the cases that remained at home as a consequence were likely of a less serious nature. But the finding was significant enough to point

out the fallacy of the original idea of establishing public sanatoria primarily for minimal cases.

It was also found that when the insignificant minimal lesions, which proved to have no activity, were eliminated, there was a certain maximum of new active minimal cases that could be discovered on any sort of survey. The institutions were found to contain from two-thirds to three-quarters of advanced cases. The conclusion, therefore, soon followed that a comparison of the mortality rates in the institutions and of discharged institutional cases with mortality rates of patients without sanatorium care failed to demonstrate advantages in treatment that were worth the trouble and expense. The greatest advantage of institutional care for tuberculosis accrued from the segregation of advanced patients from the rest of the population, particularly from the intimate contacts in the homes. If that separation of the patient from those he was likely to infect was to be effective, certainly some legal control over the movement of the patient had to be established, and not left entirely to the voluntary cooperation of the patient.

Another situation arose in which we had to go forward with a widespread public education program of the danger of the spread of the disease, or else acknowledge as a Health Department we were incapable of coping with the situation. For many years we made the rounds of all the schools in the County, tuberculin testing children and X-raying the positive reactors, and in later years attempted to examine in the same manner all household contacts of positive

reactors. We had one physician employed full time holding conferences with some responsible adult member of the positive reacting students to explain the communicability of tuberculosis. These parents, guardians and relatives were exercised over the evidence of live bacilli in the student and eagerly absorbed the information given to them orally and in pamphlet form. It was emphasized to them that the child was infected because the sputum of a person ill with tuberculosis had gotten into the mouth of the child, that such exposure continued in later years could result in chronic secondary infection, and that they had a right to demand of the Health Department that they be protected against such infection. In this situation what could we do but enforce isolation of known dangerous cases?

As a corollary and necessary contributing legal function, we had to also require by legal order the examination of refractory household contacts and reasonably suspected cases. As you may interpolate, no such arbitrary action as we have been carrying out in the control of tuberculosis is possible without the support of the general population, and the education accomplished in our school surveys created, not only a permissive attitude in our people, but an enthusiastic support of our segregation of dangerous cases. This is evidenced by the fact that in the many hundreds of arbitrary legal actions that we have instituted, there has never been any popular objection voiced to the Courts, the Health Officer, the Supervisors, or the press.

The greatest obstacle we have encountered has been a reluctance, or a fear, of officials to embark upon a new and untried legal procedure because of the theoretical responsibilities involved. Even Dr. Pomeroy, who was our County Health Officer at that time, and who was particularly interested in tuberculosis and gave us hearty support in any reasonable activity in the suppression of tuberculosis, gave his approval to the procedures with great trepidation and remained fearful for years of some embarrassing repercussion from these activities. I can remember several instances, early in our experience, where the patient made such vigorous protest to Dr. Pomeroy he summarily cancelled our order, and invariably these orders had to be reissued at a later date with Dr. Pomeroy's support. The evidence of grossly positive sputum, and oftentimes new cases developing in the family in contact with such a patient, is a challenge to any Health Officer who has the means at his disposal to suppress such spread.

Our experience in court in the many instances of prosecution for violation of isolation orders for tuberculosis has impressed us with the almost universal wholehearted support of the Justices. The only criticism expressed by these Judges has been related to the vigorous objection of patients isolated in some of our privately operated institutions housing public patients, where the care is known to be inadequate. It is going to become necessary to restrict our legal isolations to placements in public institutions approved by and subsidized by the State Department of Health. Satisfactory

isolation is not always necessarily in an institution, for we have many patients who are adequately isolated at home. All other variables from these typical situations, such as the chronic infected and more or less healed persons with rare tubercle bacilli in the sputum, or with insignificant cases with infection in the sputum demonstrable only by gastric lavage, are dealt with consistently with the facts in the individual case and the restrictions and supervision are modified as indicated.

The widespread activities of health agencies in surveying various groups of students, industrial workers, of inductees and enlistments in the combat forces and contact surveys, are of small avail if we exercise no effective control over those who are known to be spreading the disease. It is comparable to be forever bailing the boat without making an effort to plug up the leak. It would be interesting to review the activities of the various health agencies in the past generation that have accomplished so much, and brought us to the point where we now stand where it is possible to exercise adequate control over the great majority of the persons who are the source of all of our new cases. The percentage of unknown, dangerous cases is becoming smaller constantly as a result of all these activities, and will become still smaller, as the dangerous afflicted persons become more conspicuous by their rarity. Statistics, tables, percentages and all sorts of tiring figures have been scrupulously avoided in this discussion, but a request has been received for a statement of these activities in figures as experi-

enced by the Los Angeles County Health Department. The Los Angeles City Health Department has been equally active, but its figures are not included here. The first order of isolation was issued May 1, 1931, and the present legal form instituted November 11, 1931. During this period of twelve years there were 1,486 orders of isolation in institutions, 1,125 examination orders served, and there were 565 instances of the officer inducing the person to comply without serving the order. Arrests and convictions for violation of any of these orders amounted to 233. One case was lost and we felt that it was due to the prejudice of the jury against conditions in a small rural institution. One complaint was refused because it would mean life imprisonment for an habitual criminal and one or two other complaints were refused for reasons not pertinent to our study. Evasion of orders by desertion numbered 191. Those are the significant figures and there is no need to burden you further. There are many other activities incidental to this work, such as transfer of place of isolation, miscellaneous investigations and inspections, and office work of recording, filing, and termination of orders because of healing or death or return to legal residence. There have been comparatively few isolations in homes in the past, but increasing requests are being received from the health districts. A majority of those now in force are instances of transfers from institutions to homes. These transfers must be made on demand of patients when they have secured proper places of isolation in some home.

In conclusion it might be in order to advise caution against misuse of this power. Any evidence of any worker using this authority as punishment for insults, as a threat or to secure consent to treatment indicated, is summarily suppressed. There are some situations that are on the borderline of dangerous spread when other factors influence the decision such as minors experiencing neglect or treatment by flagrant quackery. This responsibility of review and decision must be the responsibility of one individual in each organization, and he must exercise all the judgment he possesses.

(Dr. Telford contihued extemporaneously as follows:)

I might say from our experience that what justices would like would be a statement as to the attitude of the State Health Department regarding the need for isolation in tuberculosis. We need such a statement to cover the question of whether the patient complies with the orders that are placed upon him by the health officer or by the deputies of the health officer, because in the Code these are already well defined, and the authority of the health officer is clearly laid down, together with the penalty for violation of his orders.

Tuberculosis is listed among the many contagious diseases in which he may take action, but tuberculosis is buried in a long list and seems a little obscure to the justices. In no place have we something definite to point to stating it is the attitude of the health department that it is necessary to isolate patients with

dangerous numbers of tubercule bacilli in the sputum.

Communicability of tuberculosis varies in individuals, and it is vastly different from the danger that exists in other diseases. We know that it takes a long, continued exposure in a home in the usual circumstances before it is spread among other members of the family, and that home is the place where it is usually acquired. On the other hand, however, we do have individual cases that are quickly and dangerously affected. We had a person of teen age last week we had X-rayed the year before and found negative who now has acute miliary tuberculosis with meningitis.

DR. BELT: Dr. Wynns, will you tell the audience about the new regulations concerning tuberculosis?

DR. H. L. WYNNS, Chief, Bureau of Epidemiology, State Department of Public Health: We have prepared new regulations that fall well within the lines that this meeting is taking. The old regulations were passed many years ago and had practically no teeth. Whatever activity was undertaken in the matter of tuberculosis was done under the General Health Laws and not under the tuberculosis regulations. It might be well to read the sections that we have written and which may be adopted with certain revisions, of course, depending somewhat on the tone of this meeting and, of course, the final consideration of the Board. At the present moment the suggested regulations are:

Part A. "Patients with positive sputum shall be considered as fulfilling the requirements of isolation as long as they are under

adequate medical supervision and observe the instructions issued by the health officer. If there are any young children in the household, the degree of isolation for the patient shall be such that the children are adequately protected and shall conform to the requirements of the health officer."

This first section is not a great deal different from the corresponding passage in the present regulations. In the past the individual who obeyed instructions of his physician and health officer was considered as fulfilling the requirements of isolation.

Section B we now have is--"Persons with a grossly positive sputum shall not engage in any occupations involving the handling of foods or come in close contact with children or young adults. Also, persons suspected of having an open case of tuberculosis shall not engage in any of these specified occupations until it has been determined to the satisfaction of the health officer that the suspected case is not a communicable case of tuberculosis."

Part C--this is the part that we are quite interested in. We would like to have everyone's reaction to this section. "Tuberculous patients with positive sputum who refuse to observe the health officer's instructions and thereby expose others needlessly to infection shall be placed in quarantine, including the placarding of the premises, until such time as the health officer feels that such quarantine is no longer necessary for the protection of the public, and in the event that such quarantine proves inadequate for the protection of members of the household or community, the patient

shall be placed in isolation in quarters designated by the health officer until such time as such isolation is no longer necessary for the protection of the public."

This paragraph, of course, allows for the old quarantine which there has been very little criticism over or objection to--quarantining a case in the home. However, all health officers have come up against the problem of quarantining an individual in the home along with two or three or four small children, and quarantine under those circumstances is unsatisfactory because those children are still exposed to an open case of tuberculosis. I know of one instance in which the individual went so far as to say that they were his children and if he wanted to spit in their soup and give them tuberculosis that was his business--not the health officer's! That is the type of individual we are dealing with. We are not dealing with the usual case of tuberculosis who is quite willing to follow regulations.

Under the above circumstances, a quarantine and placarding of the home may protect the public, but it does not protect other members of the household. So, the health officers in some instances have been able to remove the ill member from the household to other quarters. It would usually be a tuberculosis hospital. And I think that is what we are all most interested in. That has been done in this part of the State. Unfortunately, I don't think we have very many instances of that being done in other parts of the State.

I think that covers the proposed regulations. The actual wording, as I have given it, may be changed, but the section on enforced isolation should remain.

DR. BELT: The meeting is now open for general discussion.

DR. W. A. POWELL, Health Officer of Contra Costa County, Martinez: Suppose we prescribe an area of isolation and put up quarantine signs for an uncooperative tuberculous. Our county is a rural county, as are most of the communities, and, of course, the man breaks the isolation and goes around. We catch him somewhere else, eating in a public place maybe. We take him into the court. In one or two instances we have suggested to the court beforehand that this man, after he has been given a six months' sentence say, that he be suspended, provided he was sent to the county sanatorium.

The man goes to the county sanatorium, gets drunk about a week after he gets there, or he doesn't like the way they treat him under present regulations of all sanatoria--and that is where I think the center of control should be. He is allowed to go to that office and sign out. Here is an infectious disease that is allowed to go and say, "Pooh" and out he goes. He comes back to us. We put him then in contempt of court. I don't know what the legal name is, but anyway the judge will say, "You have got to go to jail and spend six months."

We have an isolation ward in the county hospital. It is unfortunate that our tuberculosis sanatorium is at Weimar, which is about one hundred miles up in the foothills, and shared by thirteen

counties. So it isn't in our county. We can't pick him up then and put him in the isolation ward, and we can't put him in the open tanks in the county jail, so we are right back where we started.

It seems to me that there is a legal side. When this man comes up to the sanatorium he carries an infectious disease. The State Board of Health, in cooperation maybe with the local authorities, could appoint the superintendent of that hospital as a deputy health officer. When this man gets into Placer County, where Weimar is located, and if the State Board of Health has regulations which say this man will be confined in that hospital unless he carries out other recommendations, the health officer, who in this instance is the superintendent of the hospital, says that he must stay there, and then if he comes and wants to sign out, the superintendent of the institution will say, "I'm sorry, but the State law won't permit."

You will say well he gets drunk and goes off anyhow. It seems to me that could be overcome in that institution by having a special ward where he would be given treatment just like anywhere else. Put a barbed wire fence around it and put him in there. Give him every consideration that the others have, except that he can't get through the gate. It seems to me something like that is going to be the solution of this problem. In the city where you have plenty of policemen and where you have your own tuberculosis sanatorium, it is different from in our own community.

Here, too, undoubtedly, as the doctor has said, you have arrangements whereby the sanatorium doesn't allow these people to

go home unless there are facilities for adequate isolation of this patient in the home. That, of course, is an ideal condition. I frequently have arrangements like that with our sanatorium. That would be ideal. But this positive patient can leave. The other day we had a man in the county hospital, suffering from hemoptysis, who had been out of the sanatorium three months. He had signed out. In their large turnover, they had lost track of the man, and we didn't know he was even out. We had no idea where he was. He was simply going all around the country.

There are other points I would like to mention, but I think the secret of this thing, especially for those who are in counties with the sanatorium in another county, and there are other counties in the same fix, is for legal machinery to be set up. Maybe I am wrong on this. A case of diphtheria couldn't go out. A case of this type can't go out of the isolation ward unless there are facilities for isolating it at home, and I don't see why we can't do the same with tuberculosis.

DR. BELT: If Dr. Robinson will tell us how Olive View treats the person who wants to go home and who is under isolation, then we will go back to Dr. Telford for the Department of Health viewpoint.

DR. JOSEPH L. ROBINSON, Olive View Sanatorium, Olive View: I think the remarks just made are extremely pertinent. Here in Los Angeles where you think perhaps we have good facilities for taking care of these people, there are about 2,300 beds for tuberculosis, and for about a year we have carried on a very active isolation

policy in cooperation with the health department. In that year we have learned a few things about the advantages and difficulties of such a policy.

Olive View has many patients who are under an order of isolation, and some of them have been returned. Our greatest difficulty has been with the chronic offenders, the so-called recalcitrant, about whom this conference was called. We have said to ourselves on several occasions that the problem would be greatly simplified if we had somewhere a sort of penal institution where these recalcitrants could be placed, they would be unable to leave and could at the same time have proper treatment for their tuberculosis. When a patient breaks an order of isolation here, the health department first tries to find him and return him to the institution from which he left. If the patient is unwilling to return, then he is brought to court before the justice of the territory in which he resides and is probably sentenced. If he is sentenced, he is apt to be put in jail. If he is sent to jail, he is not getting adequate treatment for his tuberculosis, and I don't believe any of us whose main responsibility is the cure of tuberculosis are pleased about such a situation.

In this county there are a number of patients who have long records of going in and out of sanatoria. They are returned to the sanatorium and they go A. W. O. L. They are picked up and sent back to another sanatorium where they stay a week or a few months and go A. W. O. L. Then they are picked up again and they may go

to jail for awhile. During that time they are not getting any better and they are often out of the sanatorium longer than they are in it; we know that they are spreading tuberculosis during the time they are out, and the order of isolation is not effective with such individuals.

At Olive View and its associated sanatoria, when we adopted the policy of universal orders of isolation a year ago, we were somewhat dubious about what its effect would be on our patients, and in order to insure that there would be as little opposition as possible to the program, we insisted that patients coming under an order of isolation be given the same privileges in regard to passes and other privileges that other patients were given, so that they wouldn't have a feeling that they were being discriminated against, and I think as a result of that attitude we have had almost no opposition to our program among the majority of our patients.

But we still have the problem of the recalcitrant patient. We tell our patients when they threaten to leave that if they do we will report them to the health officer by telephone the moment they leave, and we feel certain that some action will be taken. This has been a deterrent factor in keeping a great many from leaving. But the habitual A. W. O. L.'er just doesn't pay any attention to such talk, so I would like again to stress the suggestion that a penal institution of some sort be made a part of our program of isolation for recalcitrant patients.

DR. TELFORD: When we began our program in Los Angeles County it immediately became apparent that eventually some sort of physical setup for the forcible control of a few individuals would become necessary. I think that will be an ultimate result of this program wherever it is instituted. Fortunately only a few of the patients would have to be confined in the "barbed wire" enclosure to make a program one hundred per cent effective. There is always an occasional individual who has no sense of responsibility. Many are borderline mental cases that cannot be controlled otherwise. It would take only a very few beds, even in this large county. I would say a place of six beds would be sufficient. The mere existence of such a place would cure many of our A. W. O. L. patients who are not afraid of jail.

As far as deputizing the superintendent of hospitals is concerned, it was considered, and we felt it practicable to put the responsibility on the patient. If the order is violated, the patient is at fault and is charged with that violation. I feel that the institution should not be burdened with the keeping of patients under these isolation orders, except in such a place as we have just been discussing. But for the vast majority I feel that all that is necessary is to issue the order for the patient and if the patient leaves, prosecute the patient.

I think the introduction of the word "quarantine" into this procedure is rather unfortunate. Quarantine is applicable to an area of danger or applicable to the confinement of persons exposed

to disease during the incubation period, being under observation to see whether they develop the disease. Strictly speaking, patients are never quarantined. Even when a patient is within the area of quarantine, the patient is isolated and the quarantine is for the observation of contacts and to prevent others having access to that dangerous area.

It is an important point, because in the minds of the courts and other workers in hospitals and in the minds of patients, quarantine has more stigma attached to it and they feel that there are greater restrictions than actually exist. I believe that speaking of the restrictions on the patient, it is very much more desirable to speak of it as isolation.

DR. BELT: Dr. Bush, have you any contribution to make?

DR. CHESLEY BUSH, Medical Director Arroyo del Valle Sanatorium, Livermore: Well, there seems to be a hiatus in this program in the State of California, and I was interested enough last year to send around a questionnaire and found that the isolation of tuberculosis in California, except for a few scattered instances, is carried out only in Los Angeles County. I also found, however, that 80 per cent of the health officers were sympathetic with the idea, but felt that the legal profession in their vicinity, and probably the public as well, were not yet sufficiently sympathetic to be of assistance. And the suggestion was given in several instances that it was an amazing thing that in Los Angeles County there never had been any organized opposition to the program. There never had been

any large sized or publicized public trial in relation to it.

As far as Alameda County is concerned, we have all of the problems that have been brought out this morning, and there seems to be no question in my mind that it would be helpful if we had some more power to isolate some of the recalcitrant patients. But it seems to me that the question, as far as the rest of the State is concerned, is not so much a matter of the opinion of the health officer at the moment, but rather the opinion of the district attorneys. I wonder, Dr. Kupka, whether there has been any organized effort to bring the district attorneys together to discuss this problem.

DR. KUPKA: Mr. Chairman, perhaps Mr. Mattoon can tell us about that.

DR. BELT: Mr. Mattoon.

MR. EVERETT MATTOON, Assistant Attorney General, Los Angeles: I don't know whether this is the stage at which you wish to enter upon the discussion of the legal phases. I happen to be in charge of the southern California office of the Attorney General's department of the State, and we have, at the request of Dr. Halverson, interested ourselves in this meeting--very gladly. Mr. Martin, the deputy in the San Francisco office of the Attorney General has been preparing a resume of the legal provisions for the purpose of this meeting, and was kind enough to come down here for that purpose, and, Dr. Belt, I think if you desire a resume of the legal provisions, Mr. Martin would be very glad to present them.

Mr. Martin was formerly a district attorney in one of the northern counties of the State where they are not as conscious of this problem, or have not been as energetic in its treatment or application, and I, having served as County Counsel here for twelve years, am of the school in Los Angeles County which developed, with Dr. Telford and Dr. Pomeroy, the approach and the technique now being applied in this county. Our attitude was one of accepting the challenge and leaning toward enforced isolation whenever it became necessary.

DR. BELT: Mr. Martin is the deputy for both the Department of Public Health and the State Board of Medical Examiners, so he has great familiarity with these medical problems.

MR. ALLEN MARTIN, Deputy Attorney General, San Francisco: I might say preliminarily anything that is stated by me today is the expression of the opinion of Allen Martin, the Deputy Attorney General, and does not necessarily constitute the expression of the opinion of my superior. It is not only a practical rule of our office, but also an essential rule that any opinion issued by our office must have the endorsement of the chief. So, I can only give you the benefit of my limited ability to engage upon the research of some of the authority in the light of limitation of time available to me.

I believe it can be said without danger of satisfactory or successful opposition that health authorities can take all reasonable steps to curb the development and the spread of tuberculosis infec-

tion. It is definitely provided in the Health and Safety Code of this State that tuberculosis is a so-called contagious, infectious, communicable disease. It is also designated as a reportable disease. On the basis of the broad power which has been vested in the various health officers by the Legislature, it is my opinion that not only can the health agencies quarantine those infected with tuberculosis, but they can go farther. They can isolate them in places where others will not be in danger of infection.

It is rather interesting to note that the books which report the decisions of our appellate courts and of our supreme courts are almost silent on the matter of quarantining and isolating tuberculosis cases. I suppose that results from the fact that the disease is slow in its development and just as slow in its retrogression, and the period of activation is less well defined than is the period of activation of other diseases, such as smallpox and measles. We have several cases in the State of California which endorse the isolating of other diseases, and, more recently, cases with venereal diseases. I think one of the cases with which all health officers are familiar is the Johnson case.

Every case turns on its own facts. No lawyer nor court can tell health officers when a case should be isolated, or when a case should be quarantined. That is a medical matter. That is something that must be decided by the health officer on a medical basis.

There is a provision of the Health and Safety Code that health officers have a right to take such steps as are reasonably necessary

to protect the public, in the event there is an existence of a disease in an infectious, communicable state, if they have reason to believe that such disease exists. Now, when you health officers shall have reason to believe that such a disease exists in such state, I don't believe any lawyer can tell you. The Code also provides for penalties which will be imposed upon those who violate any orders of restriction which have been imposed upon them by the health authorities.

However, the courts have gone to this extent--they have held that in the event the action of the health authority is attacked by the patient or someone representing the patient, the burden is on the health officer to justify his action by showing that there is reasonable cause for him to believe that the disease exists or has existed. That doesn't mean that he must prove that the disease in fact exists, because there may be reason to believe that the disease exists when upon examination you will find that the disease does not in fact exist. What constitutes reasonable cause to believe is another matter which is dependent upon the particular situation.

It's rather peculiar to observe in this section of the Health and Safety Code which provides that "any person who, after notice, violates, or who, upon the demand of any health officer, refuses or neglects to conform to any rule, order, or regulation prescribed by the State Department respecting a quarantine or disinfection of persons, animals, things, or places, is guilty of a misdemeanor," that it refers to rules with respect to quarantine or disinfection,

and that there is no reference made therein to isolation. I am wondering whether, however, the Legislature felt or thought that isolation is included in the broad term of "quarantine." I am inclined to believe that quarantine is sufficiently broad perhaps to include isolation.

The next section, however, goes farther. It provides that a person is guilty of a misdemeanor in this instance: When any person is afflicted with any contagious, infectious or communicable disease and wilfully exposes himself to the public, and so forth. I think that the mechanics are well set up by the provisions of the Health and Safety Code with respect to contagious, infectious and communicable diseases, on the basis of which the health officers are empowered to act. I think there are ample teeth in the appropriate sections of the Code to protect health officers and to enable them to go ahead.

I really believe, and I think Mr. Mattoon and our superior share that opinion with me, that this is a practical matter. It's a matter which requires education, the dissemination of information to the end that good will and cooperation on the part of the patient and on the part of the public will result. Undoubtedly, as Dr. Powell stated, it is necessary at times to restrict patients who have been isolated, and I believe that there is ample justification to isolate as well as to quarantine, and when he should do it and the manner in which he should do it is his problem.

MR. MATTOON: Do you wish to file the memorandum that has been prepared on this?

MR. MARTIN: I have prepared a memorandum. It is silent on the matter of isolation, but I think we could file this with the reporter. (This memorandum, by its reference here, is made a part of this report. See Appendix A.)

DR. BELT: It's your opinion, then, that the health officer can take any steps he sees fit, even to the use of physical force, to make these patients enter a hospital for confinement, and if they break those rules to put them in involuntary confinement or jail?

MR. MARTIN: Of course, he wouldn't have the right to put them in jail without an order of the court. He has a right to house them in quarters which are provided for the purpose of correcting their physical condition as it does exist. In the event they violate such orders, he has the authority to bring the matter through the proper channels to the attention of a court of proper jurisdiction, and in view of the provisions of the Health and Safety Code, the violator can be taken and then can be found guilty. If he is in fact guilty of a violation of the section of the Code, in other words, found guilty of a misdemeanor, then the court can mete out such penalty as is necessary, and I think it's within the power of the court, if it desires to impose probationary terms, to suspend sentence and direct the confinement of a person in a proper institution.

DR.MYRNIE GIFFORD, Assistant Health Officer, Kern County: I should like to state that we have found what you have said true in

Kern County. Not once have we had any difficulty in getting the cooperation of the district attorney. We have made mimeographed copies of Section 2554, stating the duty of the health officer to prevent the spread of certain diseases, including tuberculosis, and also the section including the penalties of violation for failure to cooperate with the health officer, and wilfully exposing others, and in no instance have we had any trouble in securing the cooperation of the District Attorney in Kern County.

For a number of years we have been requiring all of our open cases of tuberculosis to be isolated. In most instances, they have needed to be isolated in a hospital. In addition to the sanatorium, we have two wards in the Kern General Hospital.

Also, the director of our tuberculosis sanatorium has taken the stand that patients in the sanatorium must conform to certain rules, and he will not continue to allow patients to stay who break these rules. For instance, smoking is forbidden, and there are certain other rules that they must not break. So that if he releases them and they are open cases, we have to get them into the tuberculosis ward of the Kern General Hospital, and in some instances we have had them arrested. But they are never held in jail. They are brought to the psychopathic ward, as a rule, which is a locked ward. And they may stay there overnight or possibly over the week end, and then we usually transfer them to one of the tuberculosis wards.

They sometimes leave without permission, but they are persistently brought back. Sometimes they come back before they are picked up.

DR. BELT: That is a very practical review, Dr. Gifford, thank you very much. Mr. Mattoon, can you give us the details of any practical experience you have had in attempting to enforce the law? Has it come under your province to try some of these cases?

MR. MATTOON: We have had no direct administrative contact with this in the Attorney General's office for the last four years. I have merely referred to the development of the trend Los Angeles County has taken which differs from that of other counties. This is an opinion here dated September 8, 1931, which was the first assurance given Dr. Pomeroy of legal protection in his desire to isolate. This opinion back in 1931 from the County Counsel's office, which is the civil legal office of this county, gave him that assurance, and based upon that assurance he proceeded with what has developed to be the administrative policy of Los Angeles County.

In the Attorney General's office, we have various assignments. Mr. Martin is assigned to some of the administrative boards and tribunals, of which the State Board of Health is one.

But the matter of actual enforcement is relatively simple. It's not involved at all. It could be handled by anybody in the local district attorney's office and is purely routine once the courts recognize the effectiveness of the law. Although, as Mr. Martin said, the term tuberculosis itself has not yet been identified or classified with infectious and communicable diseases in the same sense that smallpox and diphtheria and measles are, I sometimes think that is a good thing. It places it on a little different

plane, but it does give rise to an erroneous conception on the part of some people as to the extent of isolation and treatment that can be applied. I see no reason why, with the gradual reaching out such as this representative group is bound to bring about, a different conception in other communities cannot be brought about similar to the one found to be highly advantageous and effective in Los Angeles County.

DR. JOHN C. SHARP, Medical Director, Monterey County Hospital: It seems to me that in this discussion one thing is important and that is the definition. What is an open case and what is an infectious case? What is a positive sputum? I have heard the term used this morning of a grossly positive sputum. I think we all know what a grossly positive sputum is, but there might be cases where sputum is not grossly positive, but which might be equally infectious from a public health standpoint. Before we proceed, I think we should have an exact definition of what we mean by an infectious case of tuberculosis.

DR. BELT: Thank you very much. I would like to have Dr. Telford and Dr. Pottenger discuss that point. Dr. Telford.

DR. TELFORD: I think Dr. Pottenger will be able to give you the information you wish on that score. When I use the term, Dr. Sharp, I have in mind the positive smear.

DR. POTTENGER: Knowing this question would come up, I looked over some of our cases which we have followed for as much as fourteen years. I think this is one of the most important questions that we

have to deal with: when is a patient infectious, when is he not, and when is he dangerous? (At this time Dr. Pottenger discussed in detail the case histories and laboratory studies of two patients who were alternately positive and negative over a period of many years.)

We have innumerable examples of this kind. One very important thing in the cases we have observed, we haven't had a single case of a contact who has developed open tuberculosis. That is very interesting. Further, not one of these patients has later broken down. That is another important thing. I think the greatest danger is to the patient himself, because he has the infection in his body and the spread can readily take place under bad circumstances. Now these patients, remember, all live under good circumstances, at a different level from many county patients. The latter, as a rule, live in overcrowded quarters. Many of them have insufficient food. These are the conditions which would make for a ready transmission of the disease and also for breakdown.

According to the Whitney Report brought out recently by the National Tuberculosis Association, two-thirds of those discharged patients who had tubercle bacilli in their sputum died within five years. Of those who were bacillus free, one-fourth broke down within five years. But that is a different point. What we are trying to discuss here is "When is a patient bacillus free?". It is in part academic, and when the sputum is very slightly infected, I do not believe that it is particularly a public health question.

But when the sputum is grossly positive, it is dangerous. Some patients do not expectorate more than 200 bacilli per day when they are positive. With this number it would be almost impossible to infect anybody unless the bacilli were put directly into the vistim's tissues. Most of these expectorations take place the first thing in the morning, and much of the time the patient does not expectorate bacillus-bearing sputum.

I am very glad to hear the expression by Mr. Martin and Dr. Telford that tuberculosis is so different from other diseases. That is true. I can see no place for the theory of the high infectiousness. If it were such a dreadfully infectious disease, the whole world would have died of it. All the population would have died of it before Koch discovered the bacillus. In my own institution, which has now run for thirty-eight years, we have not had a single infection that we know of among the personnel except one, who lived with his wife, who had tuberculosis for eight or ten years before he came to the sanatorium.

Where reasonable care is taken, most of the danger of tuberculosis is removed. There are certain people who will not take proper care. Some of these are vicious and don't care, and I think the State Board of Health or the local board of health should have the right to handle these people effectively, because society must be protected.

I rather think, too, that as the tuberculosis rate goes down, the danger is going to become greater. I think we have evidence

that a patient with primary tuberculosis infection has thereby gained a protection, since this infection stimulates the patient's immunity. Now, as the disease becomes less common as our tuberculosis infection rate goes down, we may revert to practically the same condition as our aborigines, and we know that tuberculosis in them takes a more acute form. We will have to consider more careful public health measures as this change takes place.

DR. BELT: Dr. Pottenger, in specific reply to Dr. Sharp's inquiry, what do you consider a grossly positive sputum?

DR. POTTENGER: I would reply that grossly positive should refer to sputum in which we find bacilli by direct smear. We have to bear in mind that many examinations are done carelessly. Take, for instance, the collection of sputum. What kind of specimens do you take? We take three-day specimens always. The patients guve us everything they raise, and after treatment and staining, we search it for ten minutes before we declare it negative. We use picric acid as a counterstain, which permits a film five times as thick as with methylene blue, and consequently aids in finding the organisms. I would say that any patient in whose sputum bacilli are found by direct smear is undoubtedly dangerous. I won't say quarantine or isolate all of those patients, but I think it would be practical to give boards of health the power to do it when the patient is careless and won't take care of himself properly.

DR. BELT: Would you consider incorporating a definition of positive sputum in the body of any new regulations?

DR. POTTENGER: I don't believe so. I think it would be better to have this understood by health boards without being in the Code.

DR. POWELL: I would like to ask Dr. Pottenger a question. You know the state law about tuberculosis examinations for teachers. In our county, the County Public Health Association, and the Tuberculosis Association, too, voluntarily took this upon themselves and fluoroscoped all teachers. We find a teacher who has what the fluoroscopist feels is some questionable thing. We have an X-ray and it still shows some question, and then we make sputum tests on this patient and they are negative. We don't have a stomach wash. This patient has shown a questionable shadow on the X-ray film, and still has negative sputum for a period of six specimens. Do you think the health officer would be right if he accepted the teacher as being free from active tuberculosis?

DR. POTTENGER: If a smear of that teacher's sputum is negative, I think it would be all right for her to teach.

DR. POWELL: Then we need not put her out of school?

DR. POTTENGER: I don't think that would be advisable. If we could examine all of our people and take X-rays as they are doing in the Navy and Army, it would be surprising how many infected people would be discovered. In many the infection has been there for a long period of time. Now, a small infection of this kind will often become negative, but occasionally we find a rare bacillus. However, we must bear in mind the human as well as the economic side in all these cases.

We do not want to stir up the phthisiophobia that we had away back in 1900. The worst thing we had to combat then was the fear of tuberculosis, and there is a good deal of it yet, and it ought not to be. We must remember that we are dealing with human beings, and we ought to deal with them in a humanitarian way, as long as they will cooperate with us. That is my point of view on the matter. There is one other point. If we, in the practice of isolation, use harsh measures against tuberculous patients, we are in danger of undoing one of the things that we are trying our best to accomplish: that is to get everyone to have an X-ray examination.

DR. CHARLES F. BLANKENSHIP, U. S. Public Health Service, San Francisco: Dr. Powell, sin't it rather dangerous to depend upon a sputum test, when the individual is not a patient? If she were a patient in your hospital, you would collect the sputum specimens. Where she has to collect it herself, and where there is some question as to whether she is going to teach school or not, should we not try to find some way of diagnosing active tuberculosis, other than a specimen which she brings in which may be Cousin Joe's. I have had them do that to me.

DR. CHARLES L. IANNE, Director of Tuberculosis, Santa Clara County: Going back to definition, I think we had better arrive at some definition before we get too far. Now, the County Counsel mentioned that tuberculosis is a reportable disease. For instance, if you go into a university school where the clinician is not a tuberculosis man, he is going to first rule out cancer. He is going

to rule out this and he is going to rule out that, and he is going to mention a hundred and one things, and if he gets a negative sputum, he is then going to fail to report that case.

Now we have a case of a food handler, a baker. She says she has no sputum. How can we prove it? I think those things have to be brought out plainly and a minimum made. Perhaps we shouldn't have it in the Code, but we should have a statement made from time to time by the State Board, who could, for instance, pick a committee to decide what is a minimum positive sputum or a maximum--whatever is required--and what is a reportable case. It would be a good thing to have health officers get together on that point.

DR. JOHN D. FULLER, County Health Officer, Santa Cruz: This whole subject is so controversial I think in a certain sense it answers its own questions. It seems to me that the answer lies in the very wording of the State law and must lie there. If, in the opinion of the health officer, there is reason to believe that there is a case of tuberculosis which is inimical to the public health, he should take proper action. I think it must continue to rest there. There will be differences in technicians and differences in techniques and differences in individual patients, and their mode of living and their relationship with the public, and so on. But I believe each individual case becomes a separate problem for the health officer to decide.

It seems to me that we haven't stressed the importance of contacts. I might cite one instance in which I made a study of

342 families in which tuberculosis existed, and among the 87% of contacts examined in that total group of families, 8% of the contacts had active tuberculosis. Our case-finding in tuberculosis depends on contact examination. The amount of tuberculosis found is going to vary with the number of contacts that we examine carefully and the way we go about it.

But I do think health officers must retain jurisdiction. It seems to me that the point which was made with regard to quarantine vs. isolation is excellent. I do think that isolation of the patient is the important thing. It boils down to about two, or perhaps three, matters.

One is the education of the general public, as well as the legal profession and the physicians in the community as to what constitutes infection and what a case of tuberculosis may do to that community. The tuberculosis associations have helped tremendously in such a campaign of education with the cooperation of the health authorities and others. This should be done in every community. I believe we are not going to get very far until we do have a widespread campaign of education of our legal profession. That is particularly true in some of our smaller counties where we have part-time district attorneys, where we don't have full-time personnel operating with us, where there isn't the elaborate setup of some of the larger counties. As soon as we do educate them, we find that they are very cooperative--in fact, sometimes overzealous. I have had that experience in my own county, where in

1937 I couldn't get a district attorney or any other person to issue a warrant for the arrest of a person with tuberculosis. Now they come to me and ask why I haven't signed one.

I think that the second important thing is the matter of standardization of regulations throughout the State of California with regard to release of patients from institutions. We have numerous instances of persons, non-residents of our county, who are hospitalized in other counties while their families remain in our county. We advise that they be both isolated and treated until well, until they are safe to return to our community. They go to another county, and for one reason or another they are back in our county in a month or so. We have to go through the whole procedure again. I think that before any person is released from any tuberculosis sanatorium there should be a consultation with the health officer as to whether, in his opinion, that person constitutes a menace to the public health.

Then I think the third thing perhaps is that the health officers might very well be under the guidance of the State Board in that instead of saying the health officer <u>may</u> isolate when, in his opinion, there is reason to believe--the health officer <u>shall</u> isolate when, in his opinion, a case of tuberculosis is inimical to the public health. I think the health officer's opinion is going to have to stand. Someone's opinion must be final, and the health officer has been appointed by the law. It always goes back to that matter of the existence of a reasonable doubt.

DR. BELT: Dr. Robinson, would you talk to this point? Specifically, will you give us some information on tuberculosis findings by gastric lavage?

DR. ROBINSON: Well, before I do that I would like to make a plea that we do not attempt to set up standards of communicability in the State Code. I say that because it doesn't seem to me to be the main point that we want to accomplish now. We would like to see a state-wide policy providing for isolation of recalcitrant communicable tuberculous patients, and the standards which will be enforced in any one community throughout the State will differ according to the consensus of medical opinion and practice in that community.

In southern California we have adopted rather high standards as regards communicability for tuberculosis. I would not suggest that those be made the standards in the State Code, and I certainly wouldn't like to see any less high standards placed in the State Code. So, you can see that if we tried to arrive at a compromise and set up specific standards, they would be too high for one community and too low for another. Standards of communicability change as we learn more about tuberculosis and its spread, and these change as doctors and people in the community learn more about it. I certainly don't believe that a community which has not practiced isolation at all should immediately adopt very high standards of communicability. I think they have to begin rather slowly, and so I do believe that we should not make or attempt to set up standards here.

The standard of communicability adopted at Olive View was influenced, in part, by economic considerations. We faced a peculiar situation where patients who were placed in the sanatorium under an order of isolation were not billed for their care, and patients who were placed without an order of isolation were so billed. Thus, if a patient came to the institution and the order of isolation was later rescinded, the patient would start getting bills for his care, and he would get up and leave. So, we had to adopt standards of communicability which were somewhat in keeping with our standards for discharge of the patient, and I think every community will find a similar problem connected with this program.

We thoroughly believe that a patient with only a few bacilli in his sputum is more of a danger to himself, but potentially, at least, he is more of a danger to those with whom he comes in contact than one who has no demonstrable bacilli. We have started a follow-up study of the first thousand cases on whom we made gastric lavage examinations. We have already found that the percentages of readmits is several times as high among those who left with a positive lavage examination as among those who left with a negative gastric lavage examination. This has some significance.

Another danger that I would like to mention is that of allowing the courts to place their entire emphasis upon whether the sputum is positive or negative. We have protected ourselves by saying that there must be a negative sputum and a satisfactory X-ray, because we know that a patient may have a large cavity and the sputum given

may be negative. That patient will go before the court, and if the court has no opinion about tuberculosis except sputum, the patient says his sputum is negative, and the court will say that patient shouldn't be held. But if the court is also educated to the fact that the patient's X-ray is of equal importance to the sputum examination, that situation wouldn't exist. We know that the patient with tuberculosis bronchitis may have days or weeks or months when he expectorates almost no sputum because the bronchial tube will be partially or completely blocked. The sputum will be maintained in the cavity and a little later on it will spill and the sputum will become very positive.

DR. BELT: Dr. Russell, a while ago Dr. Powell posed the question of administration of involuntary commitment of persons to institutions who have a grossly positive sputum and who will not submit to restraint. Particularly, Dr. Powell was interested in the mechanism of doing it in rural counties, with very small facilities for keeping people under involuntary confinement. The doctors in your community tell of the smoothness of your administration of these different public health activities. I would like to hear how you have solved them.

DR. EDWARD LEE RUSSELL, County Health Officer, Santa Ana: I didn't come here to answer questions; I came to ask them. However, I will say this, that the problem of isolation of tuberculosis patients in our community, Orange County, is not solved yet. We have patients in our pavilion who tell us that their method of

making sure of a negative stomach wash is to take a large drink of water in the morning before the wash is to be done. We know, of course, that the patient should not drink water prior to taking the wash. I suppose I was as guilty as any of promoting the stomach wash in our hospital and using it as an attempt to determine the presence or absence of infection in the patient. But we get a continuous, consecutive, negative stomach wash, even when we have positive sputums from our own laboratory. We likewise have also a difference in the reports on the sputums taken to one laboratory or to another--the county hospital or ours. We get a much higher percentage of positives from our own laboratory. I am simply stating the fact without attempting to interpret it or to state why it happened that way.

Another question that I would like to ask. Is the cavity to be considered as evidence of infectiousness, regardless of whether the sputum is positive or negative?

Likewise, I would like to ask the question of how one can go about getting the cooperation of the district attorney's office. Some of them agree that enforced isolation should be done--they will do their part, but the last case that we took to court the district attorney's deputy appeared with only the carbon copy of the complaint in his folder. That is all that he had. The case was not prepared, and amazingly enough the attorney tried the defendant on something he was not accused of and convicted him, simply on the basis of morale, because he felt that those who were

on the jury were reasonably honorable citizens and that this fact had more implications than simply the technicality of whether the defendant was guilty or not guilty. The fact was that the man lost his case in the first ten minutes because he had permitted his wife, who was the infectious case, to go out, and under Section 2601 of the Health and Safety Code, a person exposing himself or the person of another upon a public thoroughfare, knowing of this infection, is guilty of a misdemeanor. As for the wife, the patient, who was infectious--the case against her was dismissed. They were named jointly in the complaint. We have tried a different arrangement, and we hope we have solved the problem. We asked the new district attorney to assign one man specifically to health department work. He readily agreed, and gave us a man of our own choice. To date we have been very well satisfied, although we have had no tuberculosis cases.

I would also like to secure suggestions for obtaining isolation space for the incorrigible patient. We all know that tuberculosis is a long-time illness. Some tuberculosis patients tie up the two rooms in our jail for a long time. They must be used by the jail for cases of scarlet fever, chickenpox, measles, even German measles, which may come into the jail. To put tuberculosis there is hardly the thing to do. I feel very apologetic about doing it, but if the patient will not stay in voluntarily under his isolation order, those two rooms must be tied up. I think both rooms were tied up for six and eight consecutive weeks recently

with tuberculosis patients, and it so happened we had no chickenpox or other communicable disease in the jail in that period of time. If we had, we would have had to let one of the tuberculous out.

Also, I would like to know, if I can, what the mechanics are for obtaining an executive order from the State Health Officer. How can we get that accomplished? Do we have to take all the recalcitrants to court? It is a tremendously time-consuming thing. It seems to me that review by the Chief of our Bureau of Tuberculosis and of the district attorney and the obtaining of any subsequent information that the latter wants might be sufficient information for the State Health Officer to justify an executive order of isolation against a given patient.

Sometimes in our own localities we begin to lose our effectiveness. Familiarity breeds contempt. Out people have known us for so long that they become immune to what we have to say and to the restrictions that must be placed upon them. So, it is helpful when someone from the outside, unknown to the patient, says, "This can't go on any longer. You are going to have to stay home." I wonder if there isn't a way of doing this. I wonder why the state authority isn't applied more, why it can't be used more to help us in handling these problems. Certainly, it would be a different authority from a different source which is applying the restrictions upon the patient, and I believe it would have its effect.

In our county we have an open case who is not getting any treatment. He is a paranoiac. He has had two insanity hearings,

has a long career in crime, does everybody that he can as frequently as he can, and loves a fight, particularly if it gives him a chance to show off. I believe if we could use authority from some other source, he would lose his enthusiasm for a fight, because he wouldn't get the front page of the local scandal sheet. I tried to get an executive order. I was unsuccessful. Maybe I was wrong, maybe I shouldn't have asked for it, but I do feel this method can be used more often and more effectively.

DR. BELT: We will see if we can transfer some of this to Dr. Wynns. I should like him to talk to the point of the executive order that you were speaking about.

DR. WYNNS: As far as the executive order is concerned, we feel that Section 2554 gives the local health officer all the authority he needs, provided there is that justification for compulsory isolation of tuberculosis. He doesn't need the State Health Officer adding to that. The section, if it's legal, is already there. He has the necessary machinery to act.

If the custom of asking some outside authority to make an investigation were once started, it would mean health officers would ask the State to take over the cases that are highly questionable, and the State would start losing them and it would set up a rather bad precedent. The health officer would be winning the easy cases and the State Health Department would be losing the difficult ones. I think, simply stated, that the health officer has that authority under Section 2554 without any special directive.

I would like to say a word about positive sputum. It's perfectly rational for us to set up diagnostic criteria as to what constitutes a bacteriological positive diphtheria culture, and when it is once determined, the health officer is then duty-bound to carry out the procedure on that particular case of diphtheria, and it would seem that if we set up criteria as to what shall constitute a positive sputum, then the health officer is going to be duty-bound by law to carry out the provisions. Now I don't think that is the intent of this meeting--to quarantine or isolate everyone with a sputum positive for tuberculosis. It is only the occasional individual that we wish to compel to accept hospital care, and in those instances the individual is more likely to be a far advanced case with copious amounts of sputum containing large numbers of bacilli.

Another thing that I would like to bring up and ask Dr. Telford particularly about is the juvenile cases. Did the cases he spoke of all represent adults, or children also? The question I had in mind was in the north particularly the custom has been to go by way of the juvenile courts and get children awarded to the custody of the courts either because the parents had tuberculosis or because the child had, and thus assure care for the children, whether or not the adults were given care. There have been some adverse rulings on that particular phase of the question in other parts of the State.

DR. POTTENGER: One point regarding sputum I think should be understood. If we could just get the medical profession and technicians who handle sputum not to declare a case negative on one sputum sample. If you take a twenty-four or forty-eight hour sputum instead of a casual specimen, it would be all the difference in the world. Then, too, the doctor, when he gets a report from the laboratory, always backs down on his diagnosis and accepts the laboratory. We are too dependent upon laboratories, which is unfortunate. Laboratory facilities ought to be utilized for what they are worth, and clinical medicine should be utilized for what it can do. After all, I think a complete clinical conception of a case of tuberculosis is best. I never discharge a patient upon a sputum examination alone. I discharge a patient on my own clinical conception of whether or not he is well, whether he is able to go ahead. Much education is yet necessary in this matter.

DR. BELT: Dr. Telford, will you tell us about these juvenile cases? I would like to hear you discuss these cases lost in court--why we lost them and dangers confronting the health officers who are trying to enforce this law.

DR. TELFORD: I have rarely been in juvenile court. I recall one case where it was proven that there had been neglect in the care of the children. There was no question of enforcing specific treatment on the children. It wasn't a matter of whether they had tuberculosis or what they had. In that case the court took custody of the children, paroled them to me, and I had them placed in the

general hospital, where they remained for two or three years. Younger children generally are not sources of spread. But when we get into the teen age, this problem of communicability is frequently present. Then the order of isolation is issued against the parent, and if the order is violated, the parent is held responsible.

The case that we lost in court (the jury we felt was prejudiced) was in a rather isolated community where all of the residents were familiar with the conditions in the small outlying institution, and there was much to be desired in the conditions there. That was the only case that we have lost outright. The other difficulties we had were in failure to file a complaint because it would not be accepted by the justice court for various reasons. One I remember particularly was the case of a habitual criminal where one more conviction would have been sufficient to convict him for life, so the justice felt we weren't justified in making the complaint.

DR. RUSSELL: Dr. Wynns answered my question about the use of an executive order. In fact, he answered it the way I didn't want him to answer it, because I believe he didn't recognize the type of case that I am referring to. I am talking about the fellow who likes to show off and wants the center of the stage and would take any method to get it as long as he doesn't spend his own money in doing it. And I think that there is a place for some procedure that spoils the plans of a man of this kind.

I am not asking the State or anyone else to take over my responsibility for the control of tuberculosis, but I am asking for assistance in that kind of case which comes along rarely. I think that even a short review of the information that we have on file would make one realize that this is a case that needs special attention. We haven't slept on the job. We really have made a conscientious effort to control a case voluntarily, and we have used every method of restriction open to us. Those are successively applied and in some cases they are always unsuccessful, and we expect them to be. So, I think there is a place there where the State or somebody can help. In other words, if we can't do it, then who can? Can you? And it seems to me that one of the functions of the State Department of Public Health is to step in where the local situation is too difficult to be handled locally or where there has been political loading or something else that makes it impossible for the health officer to do it. To step in in his stead and assist him in getting the thing done should be a function of the State Health Department.

DR. WYNNS: The only thing I can say is that, unfortunately, there has been no case that has gone through the higher courts. If we had one, just one nice case that had been through, it would be different. It might be worth while even to pick up a case and take it through somewhere, so we would have something to lean on. We haven't that, and everyone is a little leery about what the results of that first case would be.

DR. WARREN F. FOX, County Health Officer, Riverside: We health officers who have been in public health work for quite a few years have encountered different types of legal advice--with all due respect to the members of the legal profession who are here--and I have the utmost respect for their advice. We sometimes are at a loss as to how to proceed.

Now, we have heard some question regarding the legality of the State Board of Health's regulation. But we have also heard the lawyers advise us that a health officer cannot be delegated these broad powers that certain sections of the State law provide.

I asked for a decision from my present County Counsel, and I just wish I could read it. I am not going to read it--it's too long. But I would like to raise one point for the consideration of the State Board of Health when this subject comes up. The County Counsel in my county does feel that the local health officer has the right to quarantine and/or isolate a case of tuberculosis, but Section 2571 of the Health and Safety Code, which considers the reporting of the various diseases, reads as follows:

> "***The diseases enumerated in this section, and such others as from time to time may be added by the State department, shall be quarantined whenever in the opinion of the State department that action is necessary for the protection of the public health, and shall be isolated whenever in the opinion of the department or health officer, isolation is necessary for the protection of the public health."

Again I come back to what I originally said that some attorneys feel that the construction of that section deals with the health officer meaning the State health officer, and the department meaning the State department. Therefore, in order to clarify the law, why can't we have, "and shall be quarantined and/or isolated whenever in the opinion of the department or the local health officer." Action is necessary in order to clarify that Section 2571 by adding the words "shall be quarantined or isolated" and also the word local health officer. I think that would end some of the questions that arise.

Under the broad powers granted the health officer by Section 2554, he "shall take such measures as may be necessary to prevent the spread of the disease" and it is the opinion of some that a local health officer now has the authority to require physical examination of food handlers suspected of being infected with a communicable disease. I question whether this was the intent of the legislature, and believe that this point should be cleared up. I feel that the local health officer or his representative should have the authority to require the physical examination of any food handler reasonably suspected of being infected with a communicable disease or to require the food handler to be examined by a legally qualified physician approved by the health officer. All such physical examinations would be accompanied by the submission of laboratory specimens, (X-ray, sputum, etc.) as required by the local health officer. In certain instances it might be necessary to re-

quire hospitalization in order to obtain authentic specimens.

One other point, Dr. Belt. I believe that the majority of health officers believe in the isolation of cases of tuberculosis. Why cannot we have some recommendations from the State Health Department concerning the wording of the order of isolation? Our legal adviser tells us that a quarantine isn't valid unless a placard of a certain designated nature is put on the house. Why can't we have a standard order of isolation, if we are going to isolate cases?

DR. BELT: Mr. Martin, can you help us out on that point?

MR. MARTIN: There has been a suggestion that this section be changed. If that is the opinion of the group, it would be highly desirable that you sponsor sufficient legislation.

DR. BELT: What about the possibility of changing Section 2571 to put in the word "isolation" as well as "quarantine"?

MR. MARTIN: When I was going over the matter several days ago, it struck me that there should be some clarification of that matter.

DR. BELT: Could it be done by the Board of Health?

MR. MARTIN: No, that must be done by legislation.

DR. BELT: And then there would be no objection to writing in local health officer in that same area too?

MR. MARTIN: That again is a matter of policy. It's not up to us to determine what doctors and health officers want. However, I believe the doctor's point is well taken.

DR. BELT: Miss Buben, will you discuss some of the difficulties which confronted you in confining these people?

MISS ZDENKA BUBEN, Los Angeles County Health Department: Representing social service within a health department, I should like to approach it another way. It seems to me that if we can achieve a procedure whereby we have as few barbed wire fences as possible and as little mandatory legislation endorsed to the extreme, that we will have accomplished something. Dr. Pottenger awhile ago mentioned the importance of considering the human being, and I think others mentioned the importance of health education. I believe that action with a soft pedal is best for an agency to use when it tells a patient not only that he has tuberculosis, but that he must be isolated under legal orders.

It is departmental policy to give each of those patients the opportunity of an interview with a social case worker. The reason is because we believe that if, at the point when the patient is faced with this conflict in his usual way of living, we give him an opportunity to visualize what this is going to mean to him and his family and try to offset some of the hindrances that are in his mind, he will be in a much better frame of mind to accept institutional care or the order of isolation. So our focus in that initial interview has been upon the psychological preparation of patients for the acceptance of the legal isolation order, as well as any other form of placement which removes him from his home and the community.

The medical profession, public health officers and others in the medical care field have not focused enough on that particular aspect of service. I say that on the basis of over twenty years' experience. The social aspects of this program are exceedingly important. You can't expect any of us, when told we have tuberculosis (which alone implies long-time care) and then on top of that to be told we are going to be isolated under legal quarantine or legal isolation, to be able to accept the news without some kind of psychological block.

In our department the interview between the medical social worker and the patient varies in length from half an hour to as long as two hours. The average interview is about forty-five minutes, and I would judge that in more than ninety percent of the cases we are able to get, at least at that point, a good response from the patient. In the small percentage who will not accept this, the worker goes back to the doctor and explains the patient's point of view, and then the doctor makes the decision as to the next step.

There is a period, of varying duration, during which the patient waits for placement, and that gives the worker an opportunity to go into the home, and, if necessary, to work further with that individual. The sort of questions raised in the interview are, "What is to become of my children?" Lately we have been hearing, "Do I have to pay any income tax if I go to the sanatorium?" There is

always the question of finance, and the patients invariably ask what it is going to cost.

We have been educating them, if you like to call it that, in the importance of doing this for the sake of their family and the community. We appeal to their sportsmanship to respond on that basis. We tell them that when they are able to help they should do it, and that if we can help them with any problem that stands in the way, that is what we are for. We also tell them that while they will not need to pay for the cost of living while they are under legal isolation, they will need to pay after their isolation is terminated. We prepare them for the whole experience and for whatever may happen to them.

We also tell them that isolation does not imply that they will be treated differently from other patients provided they cooperate with the medical authorities, and we also tell them that if they find they just must go A. W. O. L. for some reason or other, will they please come and tell us. We get quite a few who come back to the agency that placed them under legal isolation, after they leave the sanatorium, to tell why they couldn't stay there. As Doctor Robinson and Dr. Telford and other doctors here have said, there must be a close cooperation between the sanatorium and the health department. The right hand should know what the left hand is doing in tying up this program.

If I could make one statement of contribution, here it is: Let's not miss the boat in the preparation of the patient psycho-

logically for this period of separation from the world, so that as few cases as possible will require court action. It's a reflection on us, the doctors, the public health nurses, the social workers, all of us down the line, if the patient breaks orders and becomes a problem of isolation.

DR. BUSH: Might it not be worth while to take a case through court in order to clarify the situation?

DR. BELT: That is a question for Mr. Martin to answer. Do you think we should make an example of someone?

MR. MARTIN: You would have to have someone who is recalcitrant.

DR. RUSSELL: I've got one.

DR. BELT: What next? Dr. Russell has one.

MR. MARTIN: We can't suggest any means by which a matter of this kind may come to our attention, because it originally will be in the hands of the local law enforcement agencies and ultimately if it goes up and is appealed it will reach our office. It is a matter in which this office could not make any suggestion, because it's not within our jurisdiction at this time.

DR. BELT: That sounds very legal.

MISS BUBEN: I would like to say to Dr. Russell that he would lose his case anyway. He said awhile ago the patient was a paranoiac. When you have a mental patient, one who wouldn't understand the responsibility, I am sure the jury would go against you.

The other point I would like to make, to go back to my remarks

a minute ago, is that our County Department of Institutions recently released some figures comparing the cancellations of placements in areas where there was some family planning prior to the patient's accepting the placement, as compared to areas where there was no family planning as a preliminary, and it was, I think, 22% as compared with 47% in favor of the area where there was some preliminary planning.

DR. BELT: This is a good time to pause for lunch and then return to the afternoon session.

(The meeting adjourned at 11:45 a. m., and reconvened at 1:15 p. m.)

DR. BELT: The meeting will come to order. Dr. Kupka, would you like to continue the discussion?

DR. KUPKA: Among the questions brought up this morning is the matter of using cavities as a criterion of activity when the sputum is negative for short times or for given specimens. I believe that the decisions: first, whether the tuberculous is active, and, second, whether the patient is a menace, are up to the health officer, and that an evaluation should be made separately on every case. If the health officer wishes to consider the cavity at its full significance and consider negative sputum findings temporarily as less important, that is up to him. It's another aspect regarding which we shouldn't set rigid standards.

Then there is the question of the district attorney's office cooperating with the health officer. This has been the most diffi-

cult point with those health officers who have told me, "Doctor, I cannot go ahead with what both you and I agree is the proper thing to do because Mr. So-and-so says it can't be done," or "Mr. So-and-so doesn't want to do it." Well, we invited an equal number of district attorneys and health officers to this meeting. You see how few of the attorneys and how many of the health officers have come. Health officers are very much interested in this problem as a group; the district attorneys are not so interested. And I believe that as individuals, and perhaps as a department, speaking for the State Department of Public Health, we may work on the problem of interesting and "educating" the district attorneys and other law enforcement officials.

Another point that was brought up this morning, which as time goes on seems to be growing in sifnificance and in necessity: Many years have passed since Governor Pardee in 1903 turned down the recommendation of a committee on which Dr. Pottenger was serving to build a State sanatorium. Because California had no adequate public sanatoria, it was thought that a State sanatorium was the best solution.

In the intervening forty years sentiment has favored county sanatoria, and, by and large, that sentiment is justifiable. It has given us 6,000 free beds for tuberculosis, most of them adequate by the standards of the Bureau of Tuberculosis. But there are certain categories of patients, relatively narrow categories, such as the state resident who is a county non-resident, the state non-

resident who is awaiting transfer to his state or who, for some reason, should not be sent to his state. Then there are counties whose population is so small they cannot be expected to build a tuberculosis sanatorium or even a tuberculosis wing; for example, Mono County or Del Norte County. The state sanatorium could take patients like these. Lastly, and most germane to our discussion, it could be a place of isolation for incorrigibles, providing means of restriction and policing on a state basis.

Sentiment on this matter is divided. I have spoken to many men around the State who are interested in this matter, and some are strongly opposed to a State institution. I am beginning to feel that it may be a good solution to some of these problems. It might be worth talking up as a post war project, since there may be funds for capital expenditure on State institutions after the war.

DR. IANNE: Let us approach the isolation problem from the viewpoint of a small county. In a little institution like ours in Santa Clara County, where we have 100 beds in a clapboard type of building, a patient can make himself very obnoxious. If we had a patient there even as a probation case, he could make himself offensive in many ways, since we have no way of segregation. Therefore, we would be very heartily in accord with Dr. Kupka's idea of a state institution which would also be the place for the reception of the recalcitrant patient.

Then, secondly, we at all times have approximately five to ten percent non-resident patients from outside the State, and I think

that burden should be lifted from the communities. If we removed our ten percent, that would give us the beds for other purposes.

DR. BELT: Is there any other discussion to the point?

DR. POWELL: If a fellow sticks his chin out, somebody hits him. I don't want to give the impression that in Contra Costa County if we find a case of tuberculosis we immediately tell a nurse to go to him and say, "You have got tuberculosis and what are you going to do about it? You have got to go to the sanatorium."

I think those communities which are lucky enough to have social workers are indeed fortunate, but many of our communities do not have medical social workers. But I think the public health nurse, too, is an excellent medical social worker. She understands the background of these patients and their psychology and all that. And I do want to say I also have the cooperation of the legal profession in my county. The district attorney and the judges in my county are very fine. They cooperate with us in every way. We have two patients in the county now, out of around 250,000, who are not complying with our recommendations, which will, of course, rather indicate that we don't go around with a roll of barbed wire in the back of our automobile.

There are other questions, though, on the legal end of it, that should be considered. We have, for instance, the shipyard worker. He lives in a community that had 3,000 people a year ago and how has

30,000, or in another community that had 25,000 a year ago and now has 150,000. How can we control a case of tuberculosis in those people? They are living in trailers. They have five or six people in the family. There are no facilities for isolation. The man says, "I am going to work anyway." I should like to find out, if this man won't stay at home, whether we can keep him from going back to work. Can we control him? Should we notify that shipyard that this man has tuberculosis? That brings up the question of professional confidence, so must we have his written permission to transfer his record from place to place? Could we legally notify that shipyard that so-and-so has tuberculosis, in what we consider a communicable stage, and would they immediately throw him out? Maybe Dr. Telford can answer this.

DR. TELFORD: They won't throw him out. They are short of help. You can't prohibit a man from building ships, if he has tuberculosis. You can prohibit certain occupations. In this county we have included barbering and beauty work. But you are shifting the responsibility to the employer and he hasn't any basis for excluding them either. The solution of such a problem is to isolate him and then he cannot leave to go to work, if he is a danger to the community.

DR. FULLER: Apropos of that general point, I would like to hear some discussion by other health officers and people here about the second paragraph of the suggested new regulations that were read this morning. Personally, I feel a little unhappy about putting in

a regulation of the State Board a limitation upon the health officer in the control of communicable forms of tuberculosis relative to the contact with children or young adults, which I believe is the way you stated it, and if the person is engaged in the profession of food handling. In other words, it seems to me that it's still a communicable disease and it still costs just as much money to take care of an older person, and what again is your definition of a young adult, and how many people in the shipyards are gradually becoming older adults? We read in the papers that we are going to get people in the shipyards and in other industries up to the age of sixty, and in my own particular bailiwick I for one would be inclined to isolate persons with tuberculosis, regardless of their age or occupation.

DR. BELT: Would you like to have Dr. Kupka read that section?

(Section B of the proposed regulations was read as follows:

> "Persons with a grossly positive sputum shall not engage in any occupations involving the handling of foods or come in close contact with children or young adults. Also, persons suspected of having an open case of tuberculosis shall not engage in any of these specified occupations until it has been determined to the satisfaction of the health officer that the suspected case is not a communicable case of tuberculosis.")

DR. WYNNS: This section was introduced at the request of several health officers who, in reading the first preliminary regulations and in commenting upon them, asked to have this phrase added: "Persons with grossly positive sputum shall not engage in

any occupations involving the handling of foods or come in close contact with children or young adults."

DR. FULLER: Is that a limiting regulation or simply an additional advisory statement? In other words, does that limit your isolation procedure to that group?

DR. WYNNS: Along that line, Dr. Fuller, I think that in ordinary circumstances, if you had an elderly person with tuberculosis and there was no one else in the household except his wife, there would be no particular reason why you couldn't put a quarantine sign on the house. The only person endangered is the wife or husband in this particular instance. You are protecting the public. The quarantine would do that. The public health is protected, except for that one exception.

On the other hand, if there were children in that household, you don't want to quarantine that household. You want some other lever. You want to be able to drive up an ambulance to the door and take that individual out of there, and that is the particular implication in that sentence. That was pointed out when we sent those early regulations around. It is not a limiting factor. I don't think that it should be interpreted in that way. I think it's just an additional lever to use if people in the household are being exposed.

DR. FULLER: I understand that and perhaps my point wasn't clear. Perhaps I did not understand, but I gathered that the isolation procedure available to the health officer was going to

be limited to those engaged in certain occupations and in relationship to certain age groups, etc., which I thought was unwise.

DR. WYNNS: There is an angle there all right.

DR. KUPKA: I would just as soon cut it out entirely and leave the matter to the judgment of the health officer.

DR. FOX: There is a law already to cover that--that no employer shall permit a person to work with any infectious disease. We have regulations that provide that no person known to be infected with communicable diseases or suspected of being infected with communicable diseases, shall engage in any commercial handling of food, or be employed on a dairy or on premises handling milk or milk products, until the health officer determines him to be free of such diseases or incapable of transmitting infection. Section 8 of the Food Sanitation Act covers that also.

DR. WYNNS: This will be Board of Health regulation. Section 8 of the Food Sanitation Act covers the same problem about anyone having an infectious disease. So that statement in Section B could be eliminated entirely other than the fact that some felt it might add more weight. It 's just perhaps adding a little weight in one way, but it might be a disadvantage in implying a limitation, as Dr. Fuller said.

This matter has come up in other diseases. In the present regulations on diphtheria, typhoid and scarlet fever, there is specific reference to food handlers and there are other diseases in which there are no specific references except as implied in the

Health and Safety Code.

MISS BUBEN: I think what you are after is an over-all statement, something that covers the whole situation, and then you need to add in addition, "except that such and such cases shall always be." In other words, if you add it to your general language in A, that will take care of it.

DR. BELT: That is worth following up. Read Section A, please.

(Section A of the proposed regulations was read as follows:

> "Patients with positive sputums shall be considered as fulfilling the requirements of isolation as long as they are under adequate medical supervision and observe the instructions issued by the health officer. If there are any young children in the household, the degree of isolation for the patient shall be such that the children are adequately protected and shall conform to the requirements of the health officer.")

DR. BELT: Are there any other suggestions regarding the wording of this regulation of the health department?

DR. ROBINSON: I would like to see B taken out entirely and I should also like to see Section A modified and the words "tuberculosis in a communicable stage" substituted for positive sputum, because we all know how often it is difficult to establish a positive sputum. I would like to see the whole regulation made as broad as possible so as to give the individual health officer discretion and at the same time back him up with State authority. I think that can best be done by eliminating any wording which will tend to set up standards.

DR. BELT: It seems to me that is true, too. I have been listening to all of this discussion with the ears of a urologist. I have been thinking of tubercle bacilli in the urine. Now, Dr. Pottenger seems to think, and has said in discussion with me privately, that he did not believe tubercle bacilli in the urine were often a means of distributing tuberculosis. However, I have been in the habit of telling patients of mine who have tubercle bacilli in their urine to take methylene blue tablets for awhile. I put them on a rather large dose. Then in a little while they come to me and say, "Doctor, how long do I have to keep taking those blue tablets?" And I say, "Why, do they bother you?" and they say, "No, but everything in my bathroom is blue. The toilet seat is blue, and today I see the wainscoting is blue, the bowl I wash in is blue." And I say, "Everything that is blue is also covered with tubercle bacilli. If there is anybody else in the family, they cannot touch those blue things without the hazard of infecting themselves."

As a matter of fact, in one of the very interesting ceremonials in medieval times the priest would give a sermon, before which he had eaten of a bread which carried a heavy culture of chromogenic bacilli, probably B. Proteus. This, spattered by droplets and later transmitted onto the hangings behind his audience, would turn red with a heavy growth of the organism. It was a precise but unconscious demonstration of the effectiveness of the spread of an organism by droplet infection. Here we are interested in the pre-

vention of the spread of a disease by just such means. For this purpose occasionally enforcement of legal provisions is necessary. We have with us the quarantine officer of Los Angeles County. Mr. Harvey, I wonder if you would just tell us about some of the duties of enforcement?

MR. C. O. HARVEY, Quarantine Officer of Los Angeles County: In listening to the comments that have been made, I am impressed that apparently there is a universal desire for the same thing. During my indoctrination into the health department under Dr. Pomeroy and Dr. Telford, apparently I had a very fine course, and my training was that we had the laws that were necessary. However, the health laws in our State are somewhat complicated. The health officer, without question in my mind, has wide authority. In our county we have been going a step farther in taking the quarantine law and writing our own regulations for the County of Los Angeles. We also have a county code, i. e., a health code, for the same purpose of bringing that State law down into the county and giving us our authority to act.

When we first started, Mr. Mattoon was the County Counsel and Mr. McFadden, the deputy in charge of health work, could not see our viewpoint on tuberculosis at all, and I remember that for a period of some six months I fought with Mr. McFadden over the question of whether tuberculosis was a quarantinable disease, and eventually I had a long conversation with him, developing the argument step by step, using smallpox and other diseases for comparison, and when we

got through he said, "Well, I see your point. There is no question but that you have the right and authority." Then we finally got the opinion under which we worked.

The next step was with the district attorney's office. I found that many of the district attorneys and most of the lawyers do not know the health laws. They don't want to know them. For the lawyers there is very little advantage in knowing the health laws from the financial standpoint. They have to earn a living, and there is little profit in connection with that law. Many district attorneys do not know the quarantine law, and they try to avoid it because it is complicated.

This morning one health officer related how a deputy in Orange County appeared in court without his case prepared. I think that is the universal custom. The district attorney in the preliminary courts usually appears with the complaint and starts from that point. So that in our department we have been forced to brief our cases and prepare them for the district attorney's office. We take the essential data with us when we go to court and have the case prepared for him, so that he has the necessary ammunition with which to present his cases.

Our actual experience in the courts has been that the people, by and large, are in favor of what we are doing. I am reminded of one case on jury trial where the jury found the defendant guilty. It happened that the foreman of the jury was a former tuberculosis patient. She knew all about tuberculosis and was very much insulted

by the defendant's attitude, so much so that after the case was over, she gave him a lecture from the jury box. I think you will find that in these cases the public is consistently with you; the judges are with you.

The medical end of it must be well presented. Dr. Telford has been very fine in going to court with us to present the medical testimony that is necessary to get our cases over to the courts and the juries. They do not know medicine. The burden of proof rests with the health officer to decide which case shall be handled and the manner in which it shall be handled. Every case must be handled on its own merits. There can be no class discrimination or class rating.

When a patient deserts the sanatorium under our order of isolation, we try, as quickly as possible, to catch up with him. In many of those cases we found that some difficulty caused him to leave. By and large, I would say that ninety-five percent of our A.W.O.L.'s have mental difficulties or domestic troubles that bring about the desertion. About one-half of one percent are recalcitrants with whom you can do nothing but lock up. One recalcitrant will wreck all the other patients in the sanatorium.

The jails are not good places to commit them after they violate. Los Angeles County is fortunate to have a large jail. We have two tuberculosis tanks in the jail where they can take care of the patient who leaves for one reason or another. After about thirty days in jail, he is asking for a parole and wants to go back to the

sanatorium. A few recalcitrants would just as soon stay in jail. Then, occasionally, you will have one who will apply for a parole. I have one now; we have gone to great lengths with him. He has been before the court three times. He violated his pledge for the third time. The court had him picked up and sent to jail. Now he is asking for a parole to move to Arizona. The parole board asked me what I thought about it. I refused even to consider a parole for the man. He happens to be of independent means and is sufficiently able to support himself, but he is an absolute menace to anybody in the community, if he is at large. His family has means. That man should be forced, or his family should be forced, to pay his expenses and place him in an institution. He is almost a psychopathic case, in my opinion. He is still in jail, and the only thing to do with him when he comes out of jail will be to take him back to the sanatorium for probably two or three days, and when he runs away to have him arrested for another six months.

There was another one who had been in and out of sanatoria in this county for some forty years. Fortunately, Long Beach City Health authorities and police finally picked him up; he was judged insane and sent to Norwalk State Hospital. He had active tuberculosis and should not have been at large at any time.

There is one other point I should cover: the matter of diagnosis. We use a legal form of order for examination and diagnosis. We have asked the courts time and again to have suspects committed to the general hospital for examination and diagnosis, and the courts

in this county have backed us, I would say one hundred percent in all our operations. But the educational process was slow. We had to start, as I said, with our own County Counsel, the lawyers in the district attorney's office. Now we are getting uniform cooperation.

DR. BELT: Thank you very much. Mr. Martin, Dr. Kupka brought up the possibility of creating a State hospital to which these recalcitrant patients could be referred. The incorrigibles could be sent to that institution. Can you see any legal objection to that kind of an arrangement? The man would be taken from his county and put in a central place where he would not be able to break away and where he won't contaminate others, and where at the same time he can be cared for.

MR. MARTIN: Well, I would say just offhand, Dr. Belt, although the powers of the State Department are just as broad as the powers of other administrative agencies, the question arises in my mind as to whether or not this could be done in the absence of specific legislative authority. I think it probably would require such specific legislative authority before such an institution could be created and the Board empowered to commit cases of the nature mentioned by you to such an institution. That is just an offhand opinion of mine at the present time. As a practical point of view, it would be worthy of consideration.

DR. BUSH: I think Michigan has a system by which a county health officer can take his patient before a probate judge to obtain

a commitment similar to an insane case. The patient is then committed to an institution.

MR. MARTIN: So far as commitments of persons because of peculiar conditions existing, the State of California permits this to be done in certain cases; namely, if they have committed crimes. On the one hand, if they have committed felonies, they can be committed to an institution out of the county. If they are held by a court of proper jurisdiction to be habitual intemperates, they can be committed to an institution. If they are held to be narcotic addicts, they can be committed to an institution, or if they are held to be mentally ill, they can be committed. But thus far I know of no law which provides for the commitment of a person who is suffering from communicable disease.

DR. BUSH: That was special legislation in Michigan.

MR. MARTIN: In California it would require special legislation in order to permit courts to bring about the commitment of a person who is suffering from tuberculosis, probably through no fault of his own, to an institution for care.

DR. S. F. FARNSWORTH, Alameda County Health Officer, San Leandro: That brings up a point that I was wondering about. I may be in error, but there was at least one case that I recall in Alameda County in which the court held that a tuberculosis case cannot be quarantined away from the family. I think that was in 1923 in the first district court of appeal, the case of Sara Martin, and in that decision it was held that the health department had the

right to quarantine the individual in his place of residence, but that they did not have the right to take him away from his family and put him into a separate institution. Now, this question of where the individual should be quarantined has arisen in the minds, I know, of a lot of the health officers.

MR. MARTIN: I am not aware of that decision, and if that decision is the law, it cuts the foundation abruptly out from under the attitude that I have expressed and the attitude that others have expressed. It's contrary to the expression that I and my colleague, Mr. Mattoon, have made. I venture to say there may have been some other element that introduced itself into that matter. As I say, I am not aware of that decision.

DR. WYNNS: That was in a juvenile court--the question of who should have legal authority in the case.

MR. MARTIN: Well, that sheds some light on it. So many times there will be other considerations. There is the Stockton case of which you are aware and which was called to my attention, which had to do with the authority of the juvenile court to exercise jurisdiction over a child, when, as a matter of fact, the child had committed no offense to warrant her being declared a juvenine delinquent. That may have been the situation there, and if so, of course, it would not have any bearing upon the attitude that we have assumed at this time.

DR. BLANKENSHIP: Was not the petition in the Stockton case for the welfare of the child itself rather than for the public in

general on the basis that the home was not a fit place for the child to be and that she should be declared a ward of the court and put into a tuberculosis sanatorium for her own good, whereas I think the interest of most of the health officers in what we were talking about was for the protection of the public in general and not primarily for the person who has tuberculosis.

MR. MARTIN: That is correct.

DR. ROY O. GILBERT, Los Angeles County Health Department: In regard to isolation in the home, I believe it's true that where adequate facilities are available in the home no effort is made to enforce isolation elsewhere than in the home. But where those conditions are inadequate and where it does jeopardize public health through the various contacts that occur in the home, I don't believe we would ever have any trouble in gaining the support of the court in our attitude on just where that person shall be isolated; namely, a hospital.

May I say a word in relation to this proposition in general? It has been interesting to watch the way it has unfolded. I think Dr. Telford made the point that it's pretty generally accepted. The practice of legal isolation of tuberculosis has been, in general, pretty satisfactory in Los Angeles County. He didn't mention a paper published in the American Review of Tuberculosis that he wrote back in 1942 in collaboration with Dr. Emil Bogen of Olive View which sets forth data that I believe substantiates the opinion that it has been successful and has a great deal of merit.

There are a number of reasons why it has been relatively successful, at least from the jurisdiction of the Los Angeles County Health Department. One of them, probably the initial one, is the fact that Dr. Telford himself has been extremely persistent and sold on the idea. He has prosecuted his ideas against great odds at times, but he has been persistent throughout.

Another factor is that the enforcement has been with moderation. I think there should be emphasis on the fact that a health department is not just a law enforcing agency in this matter. It actually requires a good deal of public health education. There again we come to another factor in the success of the plan--the fact that the County Health Department organization has gone into action to educate the lawyers and the judges--the legal profession in general--on the importance of this measure from the public health point of view, and, incidentally, in the course of the performance of these isolation procedures, the public in general becomes very well educated. It is an excellent educational factor.

The third factor in the success is the one which Miss Buben mentioned, and that is adequate preparation of the patient. After all, when a diagnosis of tuberculosis is made and isolation is threatened, that is a pretty terrific shock to any patient. It upsets the entire economic and social equilibrium of the individual. It does require careful preparation. We have always relied on a trained social service staff to accomplish this. I want to emphasize the necessity of trained medical social service workers for

that purpose. I have heard from a number of health officers throughout the State a marked antipathy toward medical social service workers, but upon further inquiry I find that their unhappy experiences have usually been due to the fact that they have dealt with untrained medical social service workers, particularly during the ascendency of the WPA, which provided medical social workers in name, but not in quality. Where the parties do not have a medical social service, somebody has to recognize that importance and put it into effect, and that is up to the individual health officer.

Another important factor in the success of this program in Los Angeles County has been the work of the quarantine division, which has worked with moderation, with intelligence and with the health education aspects taking ascendency over the law enforcement aspects. I don't think that it's wise to lay down too strict regulations with regard to the application of isolation. There must be a good deal left to the discretion of the health officers in those matters. The State Health Department can be of great assistance not only in accomplishing standardization of procedure, but also in assisting those departments that do not have the facilities to perform the proper functions of it in relation to medical social service and health education.

DR. POWELL: There is one thing I think we all are overlooking in this health education. We talk about the legal profession and the public, but what about the private physicians? Many communities certainly are in need of education along this line. I think all

of us ought not to overlook that point. The private physician is the best public health representative we can find. He has the confidence of his people. He tells them you ought to do this or you ought to do that. He is going to help a great deal. I think all of us ought to remember that the private physician is a very important man to include in our public health education.

DR. BELT: Mr. Higby, have you any comments?

MR. W. FORD HIGBY, Executive Secretary, California Tuberculosis Association, San Francisco: Mr. Chairman, I have one or two ideas, simply as a reporter on what has been going on. It seems to me we all are in general agreement about certain things, especially among the health officers. Today, because there are so many health officers and so many tuberculosis specialists, there has been undue emphasis upon the technical side of what is tuberculosis and what isn't tuberculosis. I think you have all come to the agreement that the definition should be expressed in broad general terms and should be left in the hands of the individual health officer for exact interpretation.

There are some steps it seems to me that may be taken: (1), a broad, but positive statement by the Board of Health on this matter that could be placed in the hands of the health officers; (2), a general opinion from the Attorney General's office on the privileges and responsibilities under the law devolving upon district attorneys in relation to this matter. Now, if a county health officer had those two statements, in the most broad and general terms, then he

could approach his district attorney and his judges on this subject with some backing. That requires a health education job. I am thinking now of getting the machinery started in the voluntary associations. Then, if the health officer felt that the tuberculosis association in his county would be of assistance to him in bringing information to the district attorneys and the judges and the legal profession, I think we might be able to help.

Those, as I see it, Mr. Chairman, are the steps that we might take.

DR. BELT: Dr. Kupka, could you bring this discussion to a head with specific suggestions for legislation and for the direction of the State Board of Health as to what they had best do?

DR. KUPKA: While Dr. Stone of Madera and Dr. Fox of Riverside were directly responsible for this meeting, because of the difference of view regarding the interpretation of the law, another and more cogent reason for calling this meeting together was to give the Bureau of Tuberculosis the common average of opinion in regard to these matters. Those of you who have been here since this morning realize that we have reached a common understanding on some of the points brought up.

We can agree, and it has been said several times, that all of us want action in this matter. We want the pathway smoothed for the authority to allow us to control the incorrigible patient. Secondly, we are sure that the matter should be left to the discretion of the health officer of local jurisdiction in every case and that if

the State enters into it, it should enter to strengthen the health officer but not to act as the complainant. Thirdly, we are agreed that the present regulations regarding tuberculosis control are too diffuse and that the ones we were discussing today will represent an improvement and as such will be presented to the Board for approval, giving the health officer something definite to point to when he goes into conferences with his district attorney.

DR. BELT: Thank you, Dr. Kupka. Dr. Pottenger.

DR. POTTENGER: I have tried to put together the various suggestions that have been made regarding the new regulations, and I believe something like the following will include most of them. First, patients with active tuberculosis should be considered as fulfilling the requirements of isolation as long as they are under adequate medical supervision and observe the instructions issued by the health officer. Secondly, persons having tuberculosis in a communicable stage who refuse to observe the health officer's instructions, and thereby expose others needlessly to infection, may be placed in quarantine, including the placarding of premises until such time as the health officer feels that such quarantine is no longer necessary. In the event such quarantine proves inadequate for the protection of members of the household or community, the patient may be placed in isolation in quarters designated by the health officer until such time as such isolation is no longer necessary.

DR. BUSH: That seems clear and precise.

DR. POTTENGER: It gives the health officer all he needs.

DR. WYNNS: There is only one comment. There were a couple of "mays." As I understand it, "mays" are not so good when we go to court with them.

DR. POTTENGER: Would you like to make it "shall"? I don't want to hold the health officer responsible.

DR. BELT: Mr. Martin has a way of looking at the problem, which Dr. Russell presented, as to whether it would be advisable to take a case clear through to the superior court for a decision.

MR. MARTIN: Dr. Belt gave me a memo concerning the proposition of making a test case out of Dr. Russell's particular case, and my answer is this: out office must remain non-commital. Although we have certain supervisorial powers over the district attorneys throughout the State of California, the matter of prosecuting or not prosecuting any case, whether it has to do with a health violation or any other law violation, is a matter of discretion resting with the particular district attorney. Thus our office would not like to become involved unless there were some suggestion emanating from the particular jurisdiction in which the case arose. If motivation comes from the jurisdiction, then we will counsel with them and give them our opinions, but the initiative cannot properly come from our office. It must come through regular channels, through the district attorney's office or the city prosecutor's office or whatever office has jurisdiction over the particular case.

DR. BELT: Dr. Fuller, have you something further?

DR. FULLER: Yes, I have, Dr. Belt. I don't know how much legislation might be necessary. I hope none. But I would certainly like to see some procedure, even if it's only a reporting procedure, whereby any case, before being released from a tuberculosis sanatorium (public or private) will be reported to the health officer of proper jurisdiction. So very frequently people are released on a medical basis, when the health officer would not approve of the return of that person to the environment to which he voluntarily returns.

It might improve the situation by being in touch with the patients before they are released, or at least consulting with the director of that institution before their release. I don't know exactly what that would involve, but I think it's exceedingly important. I think we should have some standardized method of procedure regarding release of patients on a medical basis from sanatoria in general. When patients are being released on a medical basis, they should be reported so as to bring into the picture the public health aspects of the case. In other words, there should be official release, or at least some opportunity for the health officer to know what the situation is. Do I make my point clear?

DR. BELT: It's something like what the home town officers get from San Quentin Penitentiary when they release the bad boy of the neighborhood. I think that would be a very wise thing to do.

DR. BUSH: It's done routinely in our county. It may be made a part of the requirements of the Bureau of Tuberculosis for the

operation of a public institution.

DR. BELT: Would it be necessary for the legislators to pass law for this?

MR. MARTIN: No legislation would be necessary. I think a ruling of the department would be sufficient to take care of that. It can be added to the regulations.

DR. ROBINSON: Perhaps I might just mention the procedure we use here in Los Angeles County. When a patient is recommended by the medical staff for discharge, we have a sheet containing a summary of the medical information for that patient which is filled out by the physician. A copy of the sheet is sent to the local health department. That patient is not discharged from the institution until the health department has approved the home conditions. We always wait for approval from the health department.

DR. POWELL: I have been in my county for six years and I have never had that experience. I would certainly like to have it. I have particularly in my mind, Dr. Belt, the instance of a tuberculous with a highly positive sputum and with two small children in the family, with absolutely no opportunity for isolation in the home. She was released three different times from hospitals in California and sent back to my community. I didn't know she was at home until some good neighbors in the community who were public health minded told me about it.

DR. BELT: The first pair of autopsies I ever saw was upon two small children, the little children of a professor at the University

of California. He had come out here at the request of the University from the East and moved his family into what he supposed to be a very nice healthy little cottage. In a short time both of his children got tuberculous meningitis and died. He later learned that the woman who had occupied that cottage before had active tuberculosis. They had moved into the house without knowing anything about that, so his children, who were little ones in the crawling stage, were awaited by that fate.

DR. TELFORD: We have a system within our registry that keeps track of all patients and all institutions, private or public. We provide special printed forms for the purpose of reporting admissions and discharges, and we check with the institutions periodically to see if our roster is correct. If we hear of a patient's being discharged without being reported to us, we call it to the attention of the institution and in that way we obtain thorough cooperation.

DR. IANNE: We have been doing that in our county voluntarily. The sanatoria report to the health department and the health department reports to us. I think that making it a regulation would be very good for the doctor in charge of the institution. He would have something with which to hold the patient until everything is ready.

DR. BUSH: There are several problems to be considered, if I may speak for a moment, Dr. Belt. Many of the institutions are run by other organizations than the health department. There may be no connection between the institution and the health department. Very

often it becomes necessary for the institutional management to discharge a recalcitrant patient, an alcoholic or something of that sort, since the welfare of one hundred or two hundred others may be jeopardized, if that patient is not discharged. Who is to make that decision as to whether that patient is to be discharged? That frequently comes up with us. The patient possibly has some children in the home and that is a bad place for him to be. The health department says that patient should be in an institution. The institutional management says that patient cannot be kept there because he wrecks the institution. Those are real problems and the decision has to be made.

DR. IANNE: That brings up the state institution.

DR. FARNSWORTH: One question I would like to ask, Dr. Belt. In case a tuberculous individual is isolated, who must bear the cost of his isolation, and is there any legal provision for determining the person who pays the bill--the county, the city or otherwise?

DR. BELT: Who pays the cost, Dr. Kupka?

DR. KUPKA: A person under commitment cannot be expected to pay the bills.

DR. TELFORD: The law clearly states that if the health officer isolates a wage earner, he is responsible for the support of the family.

DR. BELT: The health officer is?

DR. TELFORD: Yes. Very rarely, however, does a tuberculous patient constitute the wage earner in the family, because he is too

ill to work, and when he is able to work, he insists on working. We are able through the Charities Department to secure subsistence for the family. It all comes out of the county pocketbook anyway, so that we have not set up the machinery in our department to pay subsistence for those families, but it is paid by the county.

DR. BELT: $50 a month?

DR. TELFORD: Yes.

DR. POWELL: There is the problem of the non-resident cases. If we were to embark upon a case-finding program in non-resident persons, we would find a lot of tuberculosis. Our board of supervisors has been very fine. They have taken the point of view I have suggested to them that a tuberculous is a public health menace. If the patient doesn't go to a sanatorium, we know, of course, that in a year from now we will probably have two or three cases, and by that time he is a legal resident and all three of them will go to the sanatorium.

The Federal Government is doing a great deal for these people who are working in war industries. They have furnished them with houses. They have put out lots of money. I believe one town in our county now has 125,000 as compared to 25,000 a year ago; $200,000 has been spent for landscaping alone. Free crippled children service has been furnished to them. Lots of fine things are being done for them, but nothing is done for the care of the non-resident tuberculosis cases. It isn't fair to the local taxpayers. I think a group should go after their senators and congressmen and through someone

get a Federal appropriation to care for the non-resident tuberculous. If we get a subsidy from the Federal Government for these non-resident people, it would help a great deal.

MISS BUBEN: As far as aid to children is concerned, if a father is incapacitated because of tuberculosis, there is a law that such a child may have assistance which is financed three ways--federal, state and county. It may not be enough, but the legislation does provide for aid to any children whose father is incapacitated because of tuberculosis.

So far as the non-resident is concerned, there is a precedent now in the State, in the instance of assistance to crippled children. The Federal Government has been financing the care of the child who is not a resident of California and the county from the standpoint of having lived here three years in the State and one year in the county. Until now the Federal Government has accepted that responsibility for that child.

DR. POWELL: You have got the same program on heart disease. In several counties there is a rheumatic fever program. These people are cared for completely.

DR. BELT: I believe, Dr. Blankenship, there was talk of establishing by the Federal Government of tuberculosis hospitals in the State of California. That was brought under discussion some months ago.

DR. BLANKENSHIP: The Public Health Service is rather limited in the number of beneficiaries. They have the Coast Guard, Merchant

Seamen, the men who are on Army transports, Federal employees who are injured in line of duty and a few others, but the average man on the street is not a beneficiary of the Federal Government. If there has been any discussion about any Federal hospitals for tuberculosis, I haven't heard of it. The principal objection and the one that probably backs everyone off is that if the Federal Government would be given the opportunity, authority, responsibility and the money to hospitalize the tuberculous indigents, all that would be necessary for the states that didn't have sanatoria to do would be to move their patients across a state line and they would then become Federal beneficiaries. Soon after, the Federal hospitals would have all the tuberculosis load, certainly in some of the southern states.

Some years ago a bill was introduced in Congress by Senator Robinson from Arkansas. I believe at first it did not have the support of the National Tuberculosis Association. That bill provided generally for a Federal grant of aid to States for the construction and maintenance of tuberculosis sanatoria to bring their number of beds up to standard.

MR. HIGBY: That wouldn't apply to California. We have sufficient beds.

DR. BLANKENSHIP: That is true, but if Arkansas, Kentucky and some of the other states have some place to put these tuberculosis cases---

DR. BUSH: They would still come to California. I don't know that it was included in this bill that when patients refuse to re-

turn to their state of residence that there would be a shifting or exchange of funds between states, reimbursing the state that was stuck with the non-resident.

DR. POWELL: Just try and get it.

DR. ROBINSON: I would like to suggest to you health officers that you read the Lanham Act. It has some pretty broad wording in it.

DR. BLANKENSHIP: It says specifically it cannot be used for the construction of tuberculosis hospitals, and recently there has been a ruling that it can't be used for their operation.

DR. ROBINSON: That deflates me. I thought maybe it might be used.

MISS BUBEN: For purposes of the record, I would like to point out that there are some of the active tuberculous in the State of California who have no place to go, so far as county care is concerned--the so-called county non-resident. I had one called to my attention recently who has been here for fourteen years. He has never been outside the State of California during this period. He has no county of residence. He is one of the migrants who goes with the crops and returns home periodically. So that right within our own State we need to fix responsibility for a county non-resident.

Furthermore, I would like to see an understanding of the subject of who is responsible financially on every single case, regardless of residence or anything else, so that we could fix responsibility for the care of the tuberculosis patient who is a menace to the community, whether it's local or State or Federal or joint

responsibility. There should be some authority within the State of California to determine financial responsibility for care of these individuals.

DR. BELT: It seems to me then that it has been brought out pretty clearly that the health officer has real and positive powers; that his opinions stand paramount above everything else concerning the diseased state of the patient under consideration; that smoothness in handling these afflicted people takes care of the ninety and nine; that we must exercise the real teeth that we actually do possess for the hundredth, the incorrigible. We must handle him with fearlessness and directness and dispatch, and if we get into trouble--and after all, it will be good trouble--it will finally be taken to the proper courts for a decision; that, furthermore, the State Board of Public Health must clarify and change its regulations so that they cannot be misinterpreted; that while we may need a central state hospital, and while we need definite clarification of financial responsibility, there seems to be no need for new legislation, since the decisions of the courts in the past have been largely in our favor. We do need, however, the kind of thing which the tuberculosis associations can help us with and that is education of the public, and particularly education of the legislators, the lawyers and the practicing physicians. When that has been accomplished, aroused public and professional opinion will make the control of the recalcitrant tuberculous swift and sure.

The meeting stands adjourned.

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APPENDIX A

AUTHORITY OF HEALTH DEPARTMENT TO QUARANTINE PERSONS AFFLICTED WITH TUBERCULOSIS

By Allen Martin, Deputy Attorney General

One of the most important of all health regulations is that directed to the exclusion of communicable diseases and the keeping of such diseases, when they once gain an entrance, within the smallest possible limits and providing for the establishment and enforcement of regulations by which their general dissemination shall be prevented and their continued existence rendered improbable or impossible. Power to make quarantine regulations is one of the most frequent powers conferred upon boards of health. The authority of health officers or boards of health to quarantine for scarlet fever, diphtheria, smallpox, measles, and other such common maladies, is so well recognized, both as a practical measure and by judicial endorsement, that any comment concerning such authority would be superfluous. However, it appears that no definite steps have been taken with respect to the quarantine of those infected with tuberculosis. An examination of several of the leading law digests has failed to uncover any cases in which definite judicial endorsement has been placed upon the power of health officers or boards of health to quarantine for such a disease.

However, it is my opinion that health authorities, at least in the State of California, have the power to quarantine in case of an

active case of tuberculosis. It is expressly provided in section 2558 of the Health & Safety Code:

> "Whenever in the judgment of the State department it is necessary for the protection or preservation of the public health, each health officer shall, when directed by the State department, do the following:
>
> (a) Quarantine and disinfect persons, animals, houses or rooms, in accordance with general and specific instructions of the State department."

Health & Safety Code sections 2561 and 2563 provide the mechanics for such quarantine.

Health & Safety Code section 2554 provides in part that "each health officer. . . knowing or having reason to believe that any active case of . . . tuberculosis . . . or any other contagious or infectious disease exists, or has recently existed, within the territory under his jurisdiction, shall take such measures as may be necessary to prevent the spread of the disease."

Health & Safety Code section 2524 provides, in part, that the State Department of Public Health, upon being informed by a health officer of any contagious, infectious or communicable disease may take such measures as are necessary to ascertain the nature of the disease and prevent its spread. The section further provides that the State Department may, if it considers such action proper, take possession or control of the body of any living person in order to accomplish the purposes authorized by this code section.

Health and Safety Code section 2571 classifies tuberculosis as a "reportable" disease. The last paragraph of section 2571 provides

that any of the diseases enumerated in the section and classified therein as reportable, and such others as from time to time may be added by the State department, shall be quarantined, whenever, in the opinion of the State department, that action is necessary for the protection of the public health, and shall be isolated whenever, in the opinion of the department or health officer, isolation is necessary for the protection of public health.

Health & Safety Code sections 200-209 vest the State Department of Public Health with blanket authority to take all reasonable steps and measures to protect and preserve the public health. Thus, since the legislature has recognized tuberculosis as a contagious, infectious and communicable disease, and in one of which sections (sec. 2571) specific authority to quarantine is given, it cannot be contended successfully that the health departments or health officers are without authority to quarantine and isolate for such a disease.

The courts in this State, as well as in other states, have recognized that it is sound public policy for health authorities to take reasonable steps to prevent the spread of diseases.

Grover v. Zook, 87 Pac. 638

Adams v. City of Milwaukee, 129 N. W. 518

In re Johnson, 40 Cal. App. 242

In re Culver, 187 Cal. 437

In re Arata, 52 Cal. App. 380

In re Travers, 48 Cal. App. 765.

While the powers of health authorities are very extensive and will be upheld whenever possible, and every presumption indulged in to sustain the validity of their action, their powers are not absolute. The power to quarantine must be exercised only when public necessity demands it within reasonable and fair apprehension, and not on mere suspicion. Whether a quarantine order is justified depends upon the facts of each individual case. A condition precedent to the exercise of the quarantine authority is that the health officer shall know or have reason to believe that the disease exists or has recently existed. (H. & S. Code sec. 2554.) In the exercise of this unusual power, which infringes upon the right of liberty of the individual, personal restraint can only be imposed where, under the facts as brought within the knowledge of the health authorities, reasonable grounds exist to support the belief that the person is afflicted as claimed. Where a person so restrained of his or her liberty questions the power of the health authorities to impose such restraint, the burden is immediately upon the latter to justify by showing facts in support of the order. It might be proved, for instance, that the infected person had been exposed to contagious or infectious influence; that some person had contracted the disease from him or her, as the case might be. Such proof would furnish tangible ground for the belief that the person was afflicted as claimed.

In re Arata, 52 Cal. App. 380

In re Milstead, 44 Cal. App. 239.

More than mere suspicion that the individual is afflicted is necessary to give the officer "reason to believe."

In re Shepard, 51 Cal. App. 49

In re Dayton, 52 Cal. App. 635.

If reasonable cause to believe that the person involved is afflicted with a quarantinable disease, the person may be quarantined upon a preliminary examination.

In re Milstead, 44 Cal. App. 239.

Under date of March 7, 1941, the Attorney General's office ruled that the Director of the Department of Public Health was authorized to request the health officers of a certain locality in the State to quarantine an active case of tuberculosis. (Opinion NS3330.)

CONCLUSION

1. Health authorities are authorized to quarantine for an active case of tuberculosis, upon the basis of the provisions of the Health and Safety Code, hereinabove referred to, in addition to the theme which is present in all court decisions construing these and similar health laws.

2. This authority must be exercised prudently. Reason to believe that the disease exists as a prerequisite to the quarantine must be present. The burden is on the health officer to show that reasonable cause exists.

What constitutes reasonable cause depends upon the peculiar facts of each case. The duration of the quarantine and other conditions of the same are left to the rule-making discretion of the health authorities.

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APPENDIX B

TUBERCULOSIS Section 94

Isolation shall be as defined in Section 37.

a) Persons having tuberculosis in a communicable stage shall be considered as fulfilling the requirements of isolation as long as they are under adequate medical supervision and observe the instructions issued by the local health officer. The isolation shall be adequate for the protection of persons residing within the household as well as the public.

b) Persons having tuberculosis in a communicable stage who refuse to observe the instructions of the local health officer and thereby needlessly expose others to infection shall be placed in quarantine until such time as the local health officer feels that such quarantine is no longer necessary for the protection of the public and in the event that such quarantine proves inadequate for the protection of members of the household or community the patient shall be placed in isolation in quarters designated by the local health officer until such time as such isolation is no longer necessary for the protection of the public.

c) The person officially in charge of a sanatorium or other place where tuberculosis patients are cared for shall be responsible for immediately notifying the health officer in whose territory a patient resides whenever such patient having tuberculosis in a communicable stage leaves the institution.

(From page 18 of Regulations of the California State Board of Public Health for the Control of Communicable Disease, adopted April 3,1943)

APPENDIX C

CHAPTER 6. QUARANTINE OF DISEASES

Article 1. Definitions

2500. "Health officer," as used in this chapter, includes county, town, city, and district health officers, and city and district health boards, but does not include advisory health boards.

Article 2. Functions of State Department

2521. The State department may establish and maintain places of quarantine or isolation.

2522. The State department may quarantine, isolate, inspect, and disinfect persons, animals, houses, rooms, other property, places, cities, or localities, whenever in its judgment such action is necessary to protect or preserve the public health.

2523. The State department may destroy bedding, carpets, household goods, furnishings, materials, clothing, or animals, which, in its judgment, are an imminent menace to the public health.

2524. Upon being informed by a health officer of any contagious, infectious, or communicable disease the State department may take such measures as are necessary to ascertain the nature of the disease and prevent its spread. To that end, the State department may, if it considers it proper, take possession or control of the body of any living person, or the corpse of any deceased person.

Article 3. Functions of Health Officers

2554. Each health officer and coroner, knowing or having reason to believe that any case of cholera, plague, yellow fever, malaria, leprosy, diphtheria, scarlet fever, smallpox, typhus fever, typhoid fever, paratyphoid fever, anthrax, glanders, epidemic cerebro-spinal meningitis, tuberculosis, pneumonia, dysentery, erysipelas, uncinariasis or hookworm, trachoma, dengue, tetanus, measles, German measles, chickenpox, whooping cough, mumps, pellagra, beriberi, Rocky Mountain spotted (or tick) fever, syphilis, gonococcus infection, rabies, poliomyelitis, or any other contagious or infectious disease exists, or has recently existed, within the territory under his jurisdiction, shall take such measures as may be necessary to prevent the spread of the disease.

2555. Every health officer shall enforce all orders, rules, and regulations concerning quarantine prescribed or directed by the State department.

2556. Each health officer, whenever required by the State department, shall establish and maintain places of quarantine or isolation that shall be subject to the special directions of the State department.

2557. No quarantine shall be established by a county or city against another county or city without the written consent of the State department.

2558. Whenever in the judgment of the State department it is necessary for the protection or preservation of the public health, each health officer shall, when directed by the State department, do the following:

(a) Quarantine and disinfect persons, animals, houses or rooms, in accordance with general and specific instructions of the State department.

(b) Destroy bedding, carpets, household goods, furnishings, materials, clothing, or animals, when ordinary means of disinfection are considered unsafe, and when the property is, in the judgment of the State department, an imminent menace to the public health.

When property is destroyed pursuant to this section, the governing body of the locality in which the destruction occurs may make adequate provision for compensation in proper cases for those injured thereby.

2559. Upon receiving information of the existence of Asiatic cholera, yellow fever, typhus fever, plague, smallpox, scarlet fever, diphtheria, or any other contagious, infectious or communicable disease that the State department may from time to time declare quarantinable, each health officer shall:

(a) Quarantine each case.

(b) Follow local rules and regulations, and all general and special rules, regulations, and orders of the State department in carrying out the quarantine.

2560. Each health officer who establishes any quarantine shall promptly transmit to the State department a copy of all quarantine rules, orders, and regulations, and of all subsequent changes in them, adopted by him.

2561. When all or any part of a building, house, structure, tent, or other place is quarantined because of a contagious, infectious, or communicable disease, the health officer shall fasten firmly on its most conspicuous part a yellow placard, upon which shall be printed the following words:

"Keep out. These premises have been quarantined by order of the _____. Note--Under the provisions of the Health and Safety Code of the State of California anyone entering or leaving these premises without the permission of the health officer is guilty of a misdemeanor."

The word "quarantined" shall be printed in plain and legible letters at least two and one-half inches in height.

The placard shall not be removed except by the health officer, nor shall it be defaced or obscured.

2562. When quarantine is established by a health officer, all persons shall obey his rules, orders, and regulations.

2563. A person subject to quarantine, residing or in a quarantined building, house, structure, or tent, shall not go beyond the lot upon which the building, house, structure, or tent is situated, nor put himself in immediate communication with any person not subject to quarantine, other than the health officer and the physician. The health officer maintaining the quarantine shall appoint, or have appointed, a suitable person to perform necessary outside services for the necessary wants of the persons quarantined. The person appointed shall not enter the building, house, structure, or tent, nor shall he come in personal contact with any of the persons quarantined. He shall leave at the entrance of the building, house, structure, or tent, or at such other place as may be designated by the health officer, all articles that he may bring thereto. He shall strictly observe the orders of the health officer.

2564. No instructor, teacher, pupil, or child affected with any contagious, infectious, or communicable disease that is quarantined, or that is subject to being quarantined or reported, or who resides in any house, building, structure, tent, or other place where the disease exists or has recently existed, shall be permitted by any superintendent, principal, or teacher of any college, seminary, or public or private school to attend the college, seminary, or school, except by the written permission of the health officer.

2565. No quarantine shall be raised until every exposed room, together with all personal property in the room, has been thoroughly disinfected, or, if necessary, destroyed, by or under the direction of the health officer; and until all persons quarantined have taken a thorough antiseptic bath and have put on clothing free from contagion.

2566. No milk man shall remove milk bottles or other receptacles for milk from any building, house, structure, tent, or other place in which a contagious, infectious, or communicable disease exists or has existed, nor from any place within any quarantined

district, nor at any time after a quarantine has been removed, without the written permission of the health officer; and until the milk bottles or other receptacles have been disinfected and cleaned to the satisfaction of that officer.

2567. It is unlawful for any milkman, milk dealer, or milk distributor in whose house any case of cholera, typhus fever, plague, scarlet fever, diphtheria, membranous croup, leprosy, anthrax, glanders, cerebro-spinal meningitis, whooping cough, typhoid fever, dysentery, trachoma, or tetanus exists, to continue the sale or distribution of milk until the health officer has appointed, at the expense of the county where the milkman, dealer, or distributor lives, a person to superintend his dairy, or other place where or from which he sells, delivers, or distributes milk, and all his cows, bottles, vessels, and milk utensils. The person appointed shall strictly require that any person attending to the cows, dairy, sheds, milk cans, bottles, vessels, and milk utensils, shall not have access to, nor have any communication with the persons who reside in, the infected house, except with the permission and under the inspection of the health officer.

2568. In case of a local epidemic of disease, the health officer shall report at such times as are requested by the State department all facts concerning the disease, and the measures taken to abate and prevent its spread.

2569. Each health officer shall immediately report by telegraph to the State department every discovered or known case of plague, Asiatic cholera, yellow fever, or typhus fever. Within 24 hours after investigation he shall report the cause, source, and extent of contagion and infection, and all acts done and measures adopted. He shall also make such further reports as the State department may require.

2570. Each health officer placing any case under quarantine shall, within 24 hours thereafter, report it fully, in writing, to the State department.

2571. The following shall be properly reported in writing to the State department by the health officer:

Chicken pox, erysipelas, pneumonia, epilepsy, uncinariasis, or hookworm, epidemic cerebro-spinal meningitis, trachoma, whooping cough, mumps, dengue, dysentery, tuberculosis, typhoid fever, tetanus, malaria, leprosy, measles, German measles, glanders and anthrax affecting human beings, rabies, pellagra, beriberi, syphilis, gonococcus infection, poliomyelitis, and any other disease which appears to have become epidemic.

This list of reportable diseases may be changed at any time by the State department.

The diseases enumerated in this section, and such others as from time to time may be added by the State department, shall be quarantined whenever in the opinion of the State department that action is necessary for the protection of the public health, and shall be isolated whenever in the opinion of the department or health officer, isolation is necessary for the protection of the public health.

(Amended by Stats. 1939, Ch. 375.)

2572. Each health officer, other than a county health officer, in the county shall transmit to the county health officer at least weekly in writing a report showing the number and character of infectious, contagious, or communicable diseases reported, and their location.

2573. All physicians, nurses, clergymen, attendants, owners, proprietors, managers, employees, and persons living, or visiting any sick person, in any hotel, lodging house, house, building, office, structure, or other place where any person is ill of any infectious, contagious, or communicable disease, shall promptly report that fact to the health officer, together with the name of the person, if known, the place where he is confined, and the nature of the disease, if known.

2574. Unless otherwise directed by the State department, Sections 2559, 2561 to 2563, inclusive, 2565 to 2567, inclusive, and 2569 to 2571, inclusive, of this chapter shall be strictly observed in all cases of quarantine.

Article 4. Violations

2600. Any person who, after notice, violates, or who, upon the demand of any health officer, refuses or neglects to conform to, any rule, order, or regulation prescribed by the State department respecting a quarantine or disinfection of persons, animals, things, or places, is guilty of a misdemeanor.

2601. Except in the case of the removal of an afflicted person in a manner the least dangerous to the public health, any person afflicted with any contagious, infectious, or communicable disease who wilfully exposes himself; and any person who wilfully exposes another person afflicted with such disease in any public place or thoroughfare is guilty of a misdemeanor.

2602. Any person who violates any section in Article 3 of this chapter, with the exception of 2555, is guilty of a misdemeanor, punishable by a fine of not less than twenty-five dollars ($25) nor more than five hundred dollars ($500), or by imprisonment for a term of not more than 90 days, or by both. He is guilty of a separate offense for each day that the violation continues.